

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01831

CERTIFICATE OF DEATH

01823

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Knollwood Manor Nursing Home				d. STREET ADDRESS 1329 Cambria Street 21225		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emme Pauline Anderson				4. DATE OF DEATH Month February Day 17 Year 19 69			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1884		9. AGE (In years last birthday) 84 years	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Department Store		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Frederick XXXXXXXX Laudin			14. MOTHER'S MAIDEN NAME ? Augusta XXXXXXXX Zielke				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Arvid H. Anderson 1329 Cambria St. 21225			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4124 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic Cardiovascular disease DUE TO (c) 1 day							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan. 16 , 19 69 , to Feb. 17 , 19 69 , that (I) (we) last saw the deceased alive on Feb. 13 , 19 69 , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE Ray M. Smith M.D.				22b. DATE SIGNED 2/19/69		22c. PHYSICIAN'S NAME (Type) Ray M. Smith, M. D.	
22d. ADDRESS Hahn Prof. Bldg., Box 895, Severna Pk.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/21/69	23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City or Town) (County) (State) Odenton, Md. A. A. Co.		
24. FUNERAL DIRECTOR ADDRESS McCully FH. 237 Patapsco Ave. 21225				25a. REC'D BY REGISTRAR FEB 20 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

01813

MINUTE OF DEBATE

01813



1

Feb. 15 69 Jan. 16 69 Feb. 17 69

Mr. H. H. ... Mr. H. H. ... Mr. H. H. ...

1913

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

01832		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		01824	
Item 8 Film 410 3/14/69 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) First Middle Last GEORGE F. BASINGER			2a. DATE OF DEATH Month 18 Day 69 Year		2b. HOUR M
3. SEX M	4. RACE W	5. DATE OF BIRTH 2/1/1926		6. AGE (In years lost birthday) 43 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) FAVETT, CO. PA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Anne Arundel Md.		
10. CITY OR TOWN OF DEATH Glen Burnie	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) N. ARUNDEL HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY a.a.	13c. CITY OR TOWN REVERA BEACH	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 8444 BAY, DR.	
14. FATHER'S NAME First Middle Last CLYDE BASINGER	15. MOTHER'S MAIDEN NAME First Middle Last CIARA SMITH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service) YES WORLD II	16b. SOCIAL SECURITY NO. 193-16-5200	17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic cancer of lung</u> 1621 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Frank A. Favarino	DEGREE	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 2/19/69		
22d. PHYSICIAN'S NAME (Type) Frank A. Favarino, MD	22e. ADDRESS 727 Medical Arts Bldg, 40				
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE 2-21-69	23c. NAME OF CEMETERY OR CREMATORY Normalville Cem.	23d. LOCATION (City or Town) (County) (State) Normalville, Pa.		
24. FUNERAL DIRECTOR James M. Fields - Balto. Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE FEB 19 1969	25b. REGISTRAR'S SIGNATURE Charles Judge		

43810

43810

RECEIVED
FEB 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01833

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01825

1. DECEASED-NAME (Type or Print) <i>Leon</i> First Middle Last <i>Bell</i>			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <i>2-23-69</i>			2b. HOUR <i>9 A M</i>								
3. SEX <i>Male</i>		4. RACE <i>Col</i>		5. DATE OF BIRTH <i>1-2-1907</i>		6. AGE (In years last birthday) <i>62</i> YRS.		7c. DATE PRONOUNCED DEAD Month <i>2</i> Day <i>23</i> Year <i>1969</i>		7d. HOUR <i>9 A M</i>				
7a. BIRTHPLACE (State or foreign country) <i>Ind.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>A.A.</i>					
10. CITY OR TOWN OF DEATH <i>Annapolis</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>74 East St.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <i>Laborer</i>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Ind.</i>			13b. COUNTY <i>A.A. Annap.</i>			13c. CITY OR TOWN <i>Annap.</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>74 East St.</i>		
14. FATHER'S NAME First Middle Last <i>Henry Bell</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Sadie Bell</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. <i>214-05-0925</i>			17. INFORMANT <i>Wilton Bell</i> ADDRESS <i>Annap. Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Leukemia</i> 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Over</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>E. Linhardt</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>2/13/69</i>						
EXAMINER'S NAME (Type) <i>E. Linhardt</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) <i>Ind.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>2-27-69</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>						
24. FUNERAL DIRECTOR <i>William Reese</i>				ADDRESS <i>Annap.</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>						
				DATE <i>FEB 26 1969</i>				25b. REGISTRAR'S SIGNATURE						

01022

01022

FOR THE
RECORD

Handwritten notes in the left margin, including the word "RECEIVED" and other illegible markings.

FEB 1 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
01834		CERTIFICATE OF DEATH						01826					
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR	
Daniel			(none)		BIAS		February 28 1969			12:52 M.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male		Negro		May 2, 1909			59 YRS.		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.			
Maryland		U.S.					Anne Arundel						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Annapolis			Anne Arundel Gen. Hospital										
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER						
STATE Maryland			Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		179 West St.,						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
Unkn Unkn Unkn			Unkn Unkn Unkn										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address					
No			215-12-5978		Walter Daniel Bias			179 West St., Anna M.					
18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:										1 day			
IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i>													
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive Cerebrovascular Disease</i>													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
					YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
		HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>2-1</i> , 19 <i>69</i> , to <i>2-28</i> , 19 <i>69</i> , that (I) (we) lost the deceased alive on <i>2-28</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22c. DATE SIGNED			
<i>Charles Judge</i>				<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<i>2-28-69</i>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS											
ARIS TALEX		62 Cathedral St., Annapolis, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)			
Burial		3-3-1969		Pinelawn Mem. Pk		Annapolis		A.A.		Md			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
C.E. Hicks, 111 Annapolis, Md						DATE MAR 4 1969		<i>Charles Judge</i>					

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4-11-1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
01835											
01827											
1. DECEASED-NAME (Type or print) First Middle Last Bertha Tucker BINGHAM						2a. DATE OF DEATH Month Day Year February 20 1969			2b. HOUR A.M. 9:10M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 14, 1880			6. AGE (In years lost birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Oklahoma		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 208 Claude St.		
14. FATHER'S NAME First Middle Last John Tucker				15. MOTHER'S MAIDEN NAME First Middle Last Paralee Scott							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input checked="" type="checkbox"/> no				16b. SOCIAL SECURITY NO. 577 38 0615A		17. INFORMANT Martha Wooten		Address Annapolis, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours unknown											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (has hospital) attended the deceased from <u>2/19</u> , 1969, to <u>2/20</u> , 1969, that (I) (we) lost saw the deceased alive on <u>2/20</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Richard I. Hochman, M.D.</u> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>2/20/69</u>			
22d. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.						22e. ADDRESS 16 Murray Ave., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb 22, 1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Suitland Anne Arundel Md				
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.						25a. FEB 24 1969		25b. REGISTRARS SIGNATURE <u>[Signature]</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Town PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 410 Maryland State Department of Health
2-27-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01836

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01828

1. DECEASED-NAME (Type or Print) CLARENCE			First Middle Last BOUIE			2a. DATE KNOWN OF DEATH Month Day Year 2-9-1969			1b. HOUR 1:10 A.M.				
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 7-7-1927		6. AGE (In years) MONTHS DAYS HOURS MIN 41 YRS.		2c. DATE PRONOUNCED DEAD Month Day Year February 9, 1969			2d. HOUR 1:10 A.M.		
7a. BIRTHPLACE (State or foreign country) Georgia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ANNE ARUNDEL			Md.	
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) A.A. General Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) General			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY A.A.			13c. CITY OR TOWN Annapolis			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 39 Larkin Street	
14. FATHER'S NAME First Middle Last Roosevelt Bourc			15. MOTHER'S MAIDEN NAME First Middle Last Emma Daniels			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. 266209430			17. INFORMANT ADDRESS Estelle Bourc 39 Larkin St. Annapolis	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-cranial injuries DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Acute ethylism													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 12:45 P.M. 2-9-1969				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Head hit windowsill					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Outside apt. house				21f. LOCATION Street or R.F.D. No. City or Town County State 266 Boston Apts. C. Annapolis A.A. Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Charles S. Springate				M.D. Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)								ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
								DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
								ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE 2-13-1969				23c. NAME OF CEMETERY OR CREMATORY Pine Lawn					
24. FUNERAL DIRECTOR William Reese				ADDRESS Annapolis Md				23d. LOCATION (City or Town) (County) (State) Annapolis Md					
								25a. REC'D BY REGISTRAR DATE FEB 13 1969					
								25b. REGISTRAR'S SIGNATURE Charles Judge					

83816

STATE OF TEXAS

COMMISSIONER OF HEALTH

83816

FOR 2010
HEALTH DEPT

REPORT

STATE OF TEXAS

REPORT OF THE

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83816

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01837

CERTIFICATE OF DEATH

01829

1. DECEASED-NAME (Type or print) First Middle Last JOHN JOSEPH BROWN			2a. DATE OF DEATH Month Day Year Feb 24 1969			2b. HOUR M 11	
3. SEX Male		4. RACE White		5. DATE OF BIRTH SEPT 17, 1917		6. AGE (In years last birthday) 51 YRS.	
7a. BIRTHPLACE (State or foreign country) Rockingham Co		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH AACo	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) AA General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FOREMAN		12b. KIND OF BUSINESS OR INDUSTRY ELECTRICIAN	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY AACo		13c. CITY OR TOWN GAMBRILLS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 476 Defense Hwy							
14. FATHER'S NAME First Middle Last Robert N. BROWN			15. MOTHER'S MAIDEN NAME First Middle Last Myrtle Smothers				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or (unknown) NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 241-07-2009		17. INFORMANT Address Hilda H. Brown Box 476 Gambrills, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) WASCU DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from August , 1966, to February , 1969, that (I) (we) last saw the deceased alive on Feb , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert O. Biern				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/25/69	
22d. PHYSICIAN'S NAME (Type) Robert O. Biern, M.D.				22e. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb 27, 1969		23c. NAME OF CEMETERY OR CREMATORY Overlook Cemetery		23d. LOCATION (City or Town) (County) (State) Eden North Carolina	
24. FUNERAL DIRECTOR ADDRESS Hardesty Funeral Home Annapolis, Md. 21401				25a. REC'D BY REGISTRAR 6		25b. REGISTRAR'S SIGNATURE 6 1969	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print) <i>Walter R. Burton</i>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 29 1969			2b. HOUR 7 M			
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>Feb. 5 1900</i>	6. AGE (in years last birthday) <i>69</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>2</i> Day <i>12</i> Year <i>1969</i>		2d. HOUR <i>3:15</i> M	
7a. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel Co.</i> Md.			
10. CITY OR TOWN OF DEATH <i>Edgewater</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Box 147B Rt 3 Edgewater</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Taxi driver</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>A. A. Co.</i>		13c. CITY OR TOWN <i>Edgewater</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Middle Last <i>Richard A. Burton</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Sadie J. Burton</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16b. SOCIAL SECURITY NO. <i>578-24-8935A</i>		17. INFORMANT ADDRESS <i>Mrs. Mildred A. Burton Rt. 3 Box 147B Edgewater</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5719</i> <i>Arteriosclerosis generalized</i> DUE TO, OR AS A CONSEQUENCE OF <i>Coronary Disease</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Several</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>E. Linhart</i>			M.D.			22b. DATE SIGNED <i>2-12-69</i>			
EXAMINER'S NAME (Type) <i>E. Linhart</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county) <i>BACO</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Feb 15 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>			
24. FUNERAL DIRECTOR <i>Robert S. Beall</i>				ADDRESS <i>Beall Funeral Home 1212 West St Anna Md</i>		25a. REC'D BY REGISTRAR <i>Feb 18 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Voge</i>	

01830

01830

STATE OF
NEW YORK

Name		Age		Sex		Race		Religion		Marital Status		Occupation		Education		Income		Assets		Liabilities		Notes	
John Doe		35		Male		White		Catholic		Married		Teacher		High School		\$10,000		\$50,000		\$20,000			
Jane Doe		32		Female		White		Catholic		Married		Homemaker		High School		\$8,000		\$40,000		\$15,000			
Robert Doe		15		Male		White		Catholic		Single		Student		High School		\$2,000		\$10,000		\$5,000			
Mary Doe		12		Female		White		Catholic		Single		Student		Elementary		\$1,000		\$5,000		\$2,000			
David Doe		10		Male		White		Catholic		Single		Student		Elementary		\$1,000		\$5,000		\$2,000			
Elizabeth Doe		8		Female		White		Catholic		Single		Student		Elementary		\$1,000		\$5,000		\$2,000			
Michael Doe		5		Male		White		Catholic		Single		Student		Kindergarten		\$1,000		\$5,000		\$2,000			
Christina Doe		3		Female		White		Catholic		Single		Student		Preschool		\$1,000		\$5,000		\$2,000			
Daniel Doe		1		Male		White		Catholic		Single		Student		Nursery		\$1,000		\$5,000		\$2,000			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01839

01831

1. DECEASED-NAME (Type or print) BABY			First Middle Last			2a. DATE OF DEATH Month Day Year February 6 1969			2b. HOUR 1:15 P.		
3. SEX Male			4. RACE White			5. DATE OF BIRTH Feb. 5, 1969			6. AGE (In years lost birthday) YRS. MONTHS DAYS 1 5 35		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel		
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Newborn			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland CO. Anne Arundel			13c. CITY OR TOWN Severna Park			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Rt-1, Box 125		
14. FATHER'S NAME First Middle Last Allen F. Byus			15. MOTHER'S MAIDEN NAME First Middle Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		
17. INFORMANT Allen F. Byus #13			Address			18. CAUSE OF DEATH (Enter only one cause per line for (g), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyaline membrane disease of newborn DUE TO, OR AS A CONSEQUENCE OF (b) Diabetic mother with C-section DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 28 hrs. 28 hrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12-5, 1969 , to 12-6, 1969 , that (I) (we) last saw the deceased alive on 12-6, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles B. Hargrove MD			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 2-7-69		
22d. PHYSICIAN'S NAME (Type) Charles B. Hargrove, M.D.			22e. ADDRESS HahnProfBldg., Severna Park, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 2-7-69			23c. NAME OF CEMETERY OR CREMATORY Hillcrest			23d. LOCATION (City or Town) (County) (State) Annapolis, Md.		
24. FUNERAL DIRECTOR John M. L. Parsons			ADDRESS Annapolis, Md.			25a. RECEIVED BY REGISTRAR FEB 10 1969			25b. REGISTRAR'S SIGNATURE		

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01840

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01832

1. DECEASED-NAME (Type or Print) MARGARET M. CARROLL			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 2 Day 21 Year 1969			2b. HOUR 17 M			
3. SEX F	4. RACE W	5. DATE OF BIRTH 5-10-1881	6. AGE (in years on birthday) 87 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 2 Day 21 Year 1969			2d. HOUR 17 M
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Hare Haven I. County Md.			
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) HA-NORTH HARVARD HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY A.A. GLEN BURNIE		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 301 6TH AVE. NE.		
14. FATHER'S NAME First MARCELLAS Middle ROGERS Last ROGERS			15. MOTHER'S MAIDEN NAME First MARGARET A. Middle A. Last AHERN			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. 215-222678			17. INFORMANT ESTHER B. CARROLL ADDRESS AS ABOVE						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis generalized 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.			City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE E. Linhardt			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 2/21/69			
EXAMINER'S NAME (Type) E. Linhardt			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county)			SAACO			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/24/69		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk			23d. LOCATION (City or Town) (County) (State) Glen Burnie, A. A. Md.		
24. FUNERAL DIRECTOR Raymond C. Fink				ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR FEB 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

018810

018810

Raymond C. Rink Glen Burnie, Md.
2/24/99 Glen Burnie Memorial Ex. Glen Burnie, Md.

Handwritten signature
E. Rink

CERTIFICATE OF DEATH

01833

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
Louca				Castor	Month	Day	Year	3:45 A M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	Negro		2-2-1896		73 YRS.		MONTHS	DAYS	HOURS MIN.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Denton, Md.	71-S-				Anne Arundel Co. Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie, Md.		Plaza Manor Nursing Home			Domestic			Unknown	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Md.		V		Balta.	YES <input type="checkbox"/> NO <input type="checkbox"/>	156 Cross Street			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Luthea				Kirby	Anna				Gibbs
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		212-16-3701		Catherine Turpin		Glen Burnie, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cerebral Hemorrhage								1 day	
4122 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) Septicemic Predisposition (vascular disease unknown)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1-5, 1963, to 2-6-, 1969, that (I) (we) last saw the deceased alive on 2-6- 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
Richard H. Hunt									2/7/69
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Richard H. Hunt					110 Churys Lane, Glen Burnie, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2/12/69		Mt. Auburn Cemetery		Baltimore Md			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Adolphus Halstead		1206 W north Ave		FEB 10 1969		Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																				
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																				
01842						01834														
1. DECEASED-NAME (Type or print) <i>Rose</i>						First			Middle			Last			2a. DATE OF DEATH 2 Month 27 Day 69 Year			2b. HOUR A.M. 10:45		
3. SEX Female			4. RACE White			5. DATE OF BIRTH Jan. 23, 1891			6. AGE (In years lost birthday) 78 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS.					
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.											
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired housework			12b. KIND OF BUSINESS OR INDUSTRY at home											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Glen Burnie			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 943 Sunnybrook Drive								
14. FATHER'S NAME First Middle Last John L. Maring			15. MOTHER'S MAIDEN NAME First Middle Last Mary ?																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input checked="" type="checkbox"/>			16b. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>			17. INFORMANT Mrs. Robert J. Cavanaugh			Address 5209 Benson Ave 272nd.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Diabetic</i> 2500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Ataxic Cerebral</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Edema</i>																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus, Acidosis</i>																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from 2-26, 1969, to 2-27, 1969, that (I) (we) last saw the deceased alive on 2-27-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <i>D. Dorkan</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 2-27-69											
22d. PHYSICIAN'S NAME (Type) Cenap D. Dorkan, M.D.						22e. ADDRESS 325 Hospital Drive, Glen Burnie														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/3/69			23c. NAME OF CEMETERY OR CREMATORY Landon Park Cem.			23d. LOCATION (City or Town) (County) (State) Baltimore Md.											
24. FUNERAL DIRECTOR John J. Cavanaugh Inc.						ADDRESS 20 Hollis St.			25a. REC'D BY REGISTRAR MAR 3 1969											
						25b. REGISTRAR'S SIGNATURE <i>William A. Vande...</i>														

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 2-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01843

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01835

1. DECEASED-NAME (Type or Print) CHARLES LEONARD CHANEY			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 2 Day 11 Year 1969			2b. HOUR P M	
3. SEX male	4. RACE white	5. DATE OF BIRTH July 9, 1930	6. AGE (In years last birthday) 38 YRS.	IF UNDER 1 YEAR MONTHS DAYS 	IF UNDER 24 HRS HOURS MIN. 	2c. DATE PRONOUNCED DEAD Month Feb Day 11 Year 1969	
7a. BIRTHPLACE (State or foreign country) md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A A Co	
10. CITY OR TOWN OF DEATH ANNAPOLIS			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) A.A. General			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CHAUFFEUR	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md			13b. COUNTY AA		13c. CITY OR TOWN Deale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Percy Middle CHANEY Last 			15. MOTHER'S MAIDEN NAME First NELLIE Middle DOVE Last 			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 	
16b. SOCIAL SECURITY NO. 218-26-8991			17. INFORMANT Delois H. Chaney			ADDRESS Deale, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Cardiovascular disease 4/24 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c) 							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Phasen
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION 			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 		21f. LOCATION Street or R.F.D. No. City or Town County State 			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE E. Linhardt			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 2/11/69	
EXAMINER'S NAME (Type) E. Linhardt			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ADDRESS (Street, city, town, or county) 							
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE 2-14-69		23c. NAME OF CEMETERY OR CREMATORY Smithville		23d. LOCATION (City or Town) (County) (State) Dunkirk (Cal) Md	
24. FUNERAL DIRECTOR Hardesty Funeral Home, Galesville, Md				25a. REC'D BY REGISTRAR FEB 18 1969		25b. REGISTRAR'S SIGNATURE 	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01844

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01836

1. DECEASED-NAME (Type or print) <i>Picolla (Pecola)</i>			First <i>A</i> Middle <i>A</i> Last <i>COOK</i>			2a. DATE OF DEATH Month <i>2</i> Day <i>27</i> Year <i>69</i>			2b. HOUR <i>5²⁵ A.M.</i>					
3. SEX <i>F</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>10/24/1911</i>			6. AGE (In years last birthday) <i>57</i> YRS.			IF UNDER 1 YEAR MONTHS <i>—</i> DAYS <i>—</i>		IF UNDER 24 HRS. HOURS <i>—</i> MIN. <i>—</i>		
7a. BIRTHPLACE (State or foreign country) <i>North Carolina</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>ANNE ARUNDEL Co.</i> Md.					
10. CITY OR TOWN OF DEATH <i>Crownsville, Md.</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Crownsville State Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>—</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Md.</i>			13b. COUNTY <i>Baltimore</i>			13c. CITY OR TOWN <i>Baltimore</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>821 East Chase St.</i>		
14. FATHER'S NAME First <i>A</i> Middle <i>Fred</i> Last <i>INMAN</i>			15. MOTHER'S MAIDEN NAME First <i>EMMA</i> Middle <i>Arlene</i> Last <i>?</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown <i>NO</i>			16b. SOCIAL SECURITY NO. <i>?</i>			17. INFORMANT <i>Walter Cook</i>			Address <i>821 E. Chase St Balt. Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary vascular accident</i> <i>4310</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Massive intracerebral hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Mild diabetes mellitus - obesity. FWD (2' to 6'?)</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>1/21</i> , 19 <i>69</i> , to <i>2/22</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2/22</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Nick P. Moutsox</i>			DEGREE <i>—</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>2/22/69</i>								
22d. PHYSICIAN'S NAME (Type) <i>NICK P. MOUTSOX</i>			22e. ADDRESS <i>Crownsville State Hosp. Crownsville Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>2/26/69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>MT. CALVARY</i>			23d. LOCATION (City or Town) (County) (State) <i>A.A. Co., Bt. Md.</i>					
24. FUNERAL DIRECTOR <i>MORTON J. Dyett</i>			ADDRESS <i>1701 LAURENS</i>			25a. REC'D BY REGISTRAR DATE <i>FEB 24 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

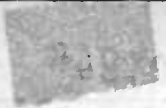
CERTIFICATE OF DEATH

01839

1. DECEASED-NAME (Type or print) <i>Marcelaine</i>		First	Middle	Last	20. DATE OF DEATH Month Day Year <i>2-28-69</i>		2b. HOUR <i>2:30</i> AM		
3. SEX <i>F</i>	4. RACE <i>C</i>		5. DATE OF BIRTH <i>10-24-96</i>		6. AGE (In years lost birthday) <i>72</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>A.A.</i>			
10. CITY OR TOWN OF DEATH <i>Millersville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Woodward Manor</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i>		13b. COUNTY <i>AA</i>		13c. CITY OR TOWN <i>Severna Park</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>Rt 2 Box 46 S.P.</i>	
14. FATHER'S NAME First Middle Last <i>Joseph Smith Sr</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Ella Dickens</i>		16. SOCIAL SECURITY NO. <i>Robert Crowner Severna Park</i>					
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		17b. (If yes give war or dates of service)		17c. INFORMANT Address <i>Robert Crowner Severna Park</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> 398X DUE TO, OR AS A CONSEQUENCE OF (b) <i>Rheumatic Heart Disease & Aortic Filneel</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes Mellitus - Insulin</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1958</i> , 19____, to <i>1969</i> , 19____, that (I) (we) last saw the deceased alive on <i>2-27-69</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Robert G. Hahn MD</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2-28-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>Robert G. Hahn</i>		22e. ADDRESS <i>P.O. Box 73 Severna Park</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-3-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Union</i>		23d. LOCATION (City or Town) (County) (State) <i>Magebus (Shade)</i>			
24. FUNERAL DIRECTOR <i>William Reesett</i>		ADDRESS <i>Clermont</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 3 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

20310

CERTIFICATE OF DEATH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 147
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<div>01847</div> <div> <div>1</div> <div>01840</div> </div>												
<div> <div>1. DECEASED-NAME (Type or print)</div> <div>First</div> <div>Margaret</div> <div>Middle</div> <div>E</div> <div>Last</div> <div>Curtis</div> </div>										<div>2a. DATE OF DEATH</div> <div>Month</div> <div>2</div> <div>Day</div> <div>1</div> <div>Year</div> <div>69</div>		<div>2b. HOUR</div> <div>P</div> <div>M</div>
<div>3. SEX</div> <div>F</div>	<div>4. RACE</div> <div>W</div>	<div>5. DATE OF BIRTH</div> <div>4-26-1892</div>		<div>6. AGE (In years last birthday)</div> <div>76</div> <div>YRS.</div>	<div>IF UNDER 1 YEAR</div> <div>MONTHS</div> <div>DAYS</div>		<div>IF UNDER 24 HRS.</div> <div>HOURS</div> <div>MIN</div>					
<div>7a. BIRTHPLACE (State or foreign country)</div> <div>MD</div>		<div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>U.S. A</div>		<div>8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>9. COUNTY OF DEATH</div> <div>Anne Arundel</div> <div>MD.</div>						
<div>10. CITY OR TOWN OF DEATH</div> <div>Annapolis</div>		<div>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>A.A. General Hospt.</div>		<div>12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)</div> <div>HOMEWIFE</div>		<div>12b. KIND OF BUSINESS OR INDUSTRY</div> <div>HOME</div>						
<div>13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE</div> <div>MD</div>		<div>13b. COUNTY</div> <div>A.A. Co</div>		<div>13c. CITY OR TOWN</div> <div>Annapolis</div>		<div>13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>		<div>13e. STREET AND NUMBER</div> <div>4 MARKET SPACE</div>				
<div>14. FATHER'S NAME</div> <div>First</div> <div>Malcolm</div> <div>Middle</div> <div></div> <div>Last</div> <div>Watson</div>		<div>15. MOTHER'S MAIDEN NAME</div> <div>First</div> <div>CARRIE</div> <div>Middle</div> <div></div> <div>Last</div> <div>Cox</div>										
<div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown</div>		<div>16b. SOCIAL SECURITY NO.</div> <div>219 16 2467</div>		<div>17. INFORMANT</div> <div>John W. MORELAND</div>		<div>Address</div> <div>77 Conduit St. Annapolis</div>						
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) Pulmonary - Edema</div> <div>180X</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Sarcoma to lung</div> <div>(c) Primary Cervical Sarcoma</div>								<div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div>				
<div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)</div>												
<div>19a. DATE OF OPERATION</div>		<div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</div>		<div>20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>		<div>20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div>						
<div>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)</div>		<div>21b. TIME OF INJURY</div> <div>HOUR A.M.</div> <div>Month</div> <div>Day</div> <div>Year</div> <div>19</div> <div>P.M.</div>		<div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)</div>								
<div>21d. INJURY OCCURRED</div> <div>While <input type="checkbox"/> Not while <input type="checkbox"/></div> <div>at work <input type="checkbox"/> at work <input type="checkbox"/></div>		<div>21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)</div>		<div>21f. LOCATION</div> <div>Street or R.F.D. No.</div> <div>City or Town</div> <div>County</div> <div>State</div>								
<div>22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost</div> <div>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the</div> <div>causes stated above, (I) (we) (did) (did not) view the body after death.</div>												
<div>22b. SIGNATURE</div> <div>William H. Smith MD</div> <div>DEGREE</div>				<div>ATTENDING PHYS.</div> <div><input checked="" type="checkbox"/></div>		<div>MED. DIRECTOR <input type="checkbox"/></div>		<div>STAFF PHYS. <input type="checkbox"/></div>				
<div>22d. PHYSICIAN'S NAME (Type)</div>				<div>22e. ADDRESS</div> <div>121 Cathedral St Annapolis MD</div>								
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div>		<div>23b. DATE</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div>		<div>23d. LOCATION (City or Town)</div>		<div>(County) (State)</div>				
<div>BURIAL</div>		<div>2-3-69</div>		<div>St. Anne's</div>		<div>Annapolis</div>		<div>A.A. MD.</div>				
<div>24. FUNERAL DIRECTOR</div> <div>John M. Lyndon Annapolis, Md.</div>												
<div>25a. REC'D BY REGISTRAR</div> <div>DATE</div>				<div>25b. REGISTRAR'S SIGNATURE</div> <div>FEB 7 1969</div>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-69
304 REV.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03283

1. DECEASED-NAME (Type or print) THOMAS First CUSTER Middle CUSTER Last		2a. DATE OF DEATH Month 2 Day 19 Year 1969		2b. HOUR 12:30 PM	
3. SEX M		4. RACE C		5. DATE OF BIRTH 3-1-1912	
6. AGE (In years last birthday) 56 YRS.		IF UNDER 1 YEAR MONTHS 36 DAYS 36		IF UNDER 24 HRS. HOURS 12 MIN. 30	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH ANNE ARUNDEL Md.					
10. CITY OR TOWN OF DEATH CROWNSVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CROWNSVILLE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. 13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTO.	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 677 W. MULBERRY			
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address CROWNSVILLE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Septicemia (clinical) pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) pulmonary fibrosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours two weeks many years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic alcoholism, Diabetes mellitus.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 12-22-1968 to 2-19-1969 , that (I) (we) last saw the deceased alive on 2-19-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Nureddin Erk. M.D.		22c. DATE SIGNED 2-19-69		22d. PHYSICIAN'S NAME (Type) NUREDDIN ERK	
22e. ADDRESS Crownsville State Hosp. M.D.		23a. BURIAL (CREMATION, REMOVAL) (Specify) REMOVAL			
23b. DATE 3-10-69		23c. NAME OF CEMETERY OR CREMATORY V. O. AD. MED. SCHOOL		23d. LOCATION (City or Town) (County) (State) BALTIMORE MD.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR DATE MAR 12 1969		25b. REGISTRAR'S SIGNATURE William J. Judge	

MEDICAL CERTIFICATION

ESTD

MASTIC DAMPPROOF

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01849

01841

1. DECEASED-NAME (Type or print) Charles T. Davis			2a. DATE OF DEATH Month 2 Day 6 Year 69			2b. HOUR 9:55 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 1-30-1		6. AGE (In years lost birthday) 68 YRS.	
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel County Md.	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. U. S. Govt.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Route 1		13f. CITY OR TOWN Marley Neck Rd.		13g. BOX Box 124		13h. ZIP CODE	
14. FATHER'S NAME First Charles Middle T. Last Davis			15. MOTHER'S MAIDEN NAME First Emma Middle M. Last Berg				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Myrtle N. Davis Address Glen Burnie Box 124 Route 1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Severe Pulmonary Emphysema DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Congestive Heart Failure							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		21g. ZIP CODE	
22a. I certify that (I) (this hospital) attended the deceased from 12-29 , 19 68 , to 2/6 , 19 69 , that (I) (we) last saw the deceased alive on 2/6 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Alejandro Montoya				22c. DATE SIGNED 2/7/69		22d. PHYSICIAN'S NAME (Type) Alejandro Montoya, M.D.	
22e. ADDRESS 707 Old Annapolis Road, Glen Burnie, Md.				22f. ZIP CODE			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/10/69		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk		23d. LOCATION (City or Town) (County) (State) Glen Burnie Md. A. A. Co.	
24. FUNERAL DIRECTOR McEulley F.H.				25a. REC'D BY REGISTRAR DATE FEB 10 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
01850		01842									
1. DECEASED-NAME (Type or print) Edward Griffin DAVIS						2a. DATE OF DEATH Month February Day 8 Year 1969			2b. HOUR 9:30 A.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 28, 1887			6. AGE (In years lost birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) 			12b. KIND OF BUSINESS OR INDUSTRY 		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 7874 Americana Cricle		
14. FATHER'S NAME First Middle Last 				15. MOTHER'S MAIDEN NAME First Middle Last 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown				16b. SOCIAL SECURITY NO. 		17. INFORMANT Address 					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left ventricular failure. 4124 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State 							
22a. I certify that (I) (this hospital) attended the deceased from 2/2 , 19 67 , to 2/8/67 , 19 , that (I) (we) last saw the deceased alive on 2/8 , 19 67 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard N. Peeler, M.D.						22c. DATE SIGNED 2/11/69					
22d. PHYSICIAN'S NAME (Type) Richard N. Peeler, M.D.						22e. ADDRESS 121 Cathedral St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2/11/69		23c. NAME OF CEMETERY OR CREMATORY Imperial Memorial Park		23d. LOCATION (City or Town) Baltimore (County) Md. (State) 					
24. FUNERAL DIRECTOR Leasch & H. Inc.		24b. ADDRESS 7401 Blair Rd. Balto Md. 21236		25a. RECORDING REGISTRATION FEB 13 1969		25b. REGISTRAR'S SIGNATURE 					

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EXHIBIT OF DATA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div>01851</div> <div> <div>01843</div> <div> <div>MD</div> <div> <div>DEPT. OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> </div> </div> </div>											
1. DECEASED-NAME (Type or print) BETTY LEE DAYTON						2a. DATE OF DEATH FEBRUARY 15, 1969			2b. HOUR 7:00 P.M.		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH OCTOBER 2, 1919			6. AGE (In years last birthday) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL Md.					
10. CITY OR TOWN OF DEATH LINTHICUM			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 510 LA CLAIR AVENUE			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) OFFICE CLERK			12b. KIND OF BUSINESS OR INDUSTRY AM. FOOD STOR		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND 13b. COUNTY ANNE ARUNDEL 13c. CITY OR TOWN LINTHICUM			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER #510 LA CLAIR AVENUE						
14. FATHER'S NAME First Middle Last AUBREY ROSS				15. MOTHER'S MAIDEN NAME First Middle Last MARY COFFMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 213 22 3108		17. INFORMANT MR. DONALD M. DAYTON (husband)				Address SAME AS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of colon DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION July 68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma Colon			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 12/14, 1968 , to 2/1, 1969 , that (I) (we) lost saw the deceased alive on 12/26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE LEYMOND W. COTTAGE		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/15/69					
22d. PHYSICIAN'S NAME (Type) LEYMOND W. COTTAGE		22e. ADDRESS 529 CAMP MEADE RD, LINTHICUM									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE FEB. 18, 1969		23c. NAME OF CEMETERY OR CREMATORY PHILOPS CEMETERY			23d. LOCATION (City or Town) (County) (State) WESTERNPORT, MARYLAND				
24. FUNERAL DIRECTOR R. Singleton		SINGLETON FUNERAL HOME GLEN BURNIE, MARYLAND			25. REC'D BY REGISTRAR FEB 20 1969		25b. REGISTRAR'S SIGNATURE [Signature]				

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)		First ELIZABETH		Middle 01852		Last DEMENT		20. DATE KNOWN <input type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> Feb. 17, 1969	
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH		6. AGE (In years lost birthday) 70+ YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		22. DATE PRONOUNCED DEAD Month Day Year Feb. 17, 1969
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel		2d. HOUR 8:00 ^a	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) N. bound track B.O. R.R. North of 176 Dorsey		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		2d. HOUR 8:00 ^a	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE ??		13b. COUNTY ??		13c. CITY OR TOWN unknown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Spring Grove State Hospital	
14. FATHER'S NAME First Middle Last George W. Price		15. MOTHER'S MAIDEN NAME First Middle Last Carrie E. Gloves		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? Head-Only YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR MIN. 8:05 P.M. 2/16/19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Subj. struck by train while walking on track					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Dorsey Road		21f. LOCATION Street or R.F.D. No. B.O.RR.		City or Town Annapolis		County State Balt. M.D.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Edward F. Wilson, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 2/17/69	
EXAMINER'S NAME (Type)		Edward F. Wilson, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/18/69		23c. NAME OF CEMETERY OR CREMATORY K. Guad. Med. School		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		25a. REC'D BY REGISTRAR DATE 20 1969	
24. FUNERAL DIRECTOR		ADDRESS				25b. REGISTRAR'S SIGNATURE J. Charles Gough			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01853

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01844

1. DECEASED-NAME (Type or print) Edith Mae DE SANTIS			2a. DATE OF DEATH Month February Day 18 Year 1969			2b. HOUR A.M. 3:35 M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 15, 1914		6. AGE (In years last birthday) 54 YRS.		IF UNDER 1 YEAR MONTHS 5 DAYS 10		IF UNDER 24 HRS. HOURS 3 MIN. 35	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOME			12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland 13b. COUNTY Anne Arundel			13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Crystal Spring Farm Rd.				
14. FATHER'S NAME First HARRY Middle WILSON Last CROFT			15. MOTHER'S MAIDEN NAME First ALICE Middle BARKER Last BARKER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. —		17. INFORMANT Ralph P. De Santis			Address # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia 571.0 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac and Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Cirrhosis, nutritional, liver. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Alcoholism.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 18 Feb , 19 69 , to Feb 18 , 19 69 , that (I) (we) last saw the deceased alive on 18 Feb , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William H. Choate, M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 18 Feb 1969			
22d. PHYSICIAN'S NAME (Type) William H. Choate, M.D.						22e. ADDRESS 2083 West St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 2-21-69		23c. NAME OF CEMETERY OR CREMATORY HILLCREST			23d. LOCATION (City or Town) (County) (State) Annapolis A.H. Md.			
24. FUNERAL DIRECTOR John M. Layton						ADDRESS Layton, Annapolis, Md.		25a. REC'D BY REGISTRAR FEB 20 1969		25b. REGISTRAR'S SIGNATURE John M. Layton	

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Items 7, 12, 17, 23 Film 410 3/11/69kl

CERTIFICATE OF DEATH

01846

1. DECEASED-NAME (Type or print) BROWN Kathryn		First 01854 Middle Downs Last		2a. DATE OF DEATH Month 2 Day 26 Year 69			2b. HOUR 12:30		
3. SEX female		4. RACE Caucasian		5. DATE OF BIRTH 9/23/20		6. AGE (In years last birthday) 48 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife / Nurse			12b. KIND OF BUSINESS OR INDUSTRY Hospitals		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1010 St. Paul Street	
14. FATHER'S NAME First Middle Last George Bland		15. MOTHER'S MAIDEN NAME First Middle Last Allie Picken							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown		16b. SOCIAL SECURITY NO. 463-58-1980		17. INFORMANT Delbert Dusold 5 Martin Dr. Millersville, Md. Hospital Records, Crownsville State Hosp.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 303.2 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic malnutrition DUE TO, OR AS A CONSEQUENCE OF (c) chronic alcoholism APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2/20/69 , 19____, to 2/26 , 19 69 , that (I) (we) last saw the deceased alive on 2/26 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Alberto Gonzalez, M.D.		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/26/69					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Crownsville State Hospital, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-1-69		23c. NAME OF CEMETERY OR CREMATORY Lake Street Cemetery		23d. LOCATION (City or Town) (County) (State) Elgin Ill.			
24. FUNERAL DIRECTOR VR A15 (4) 30M REV. 1/68		ADDRESS VR. Cook-Brooks Towson, Inc. Towson, Md.		25a. REC'D BY REGISTRAR DATE FEB 28 1969		25b. REGISTRAR'S SIGNATURE Charles J. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
Virginia Ann EADES					February 23 1969		8:35 AM		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female	Negro		Feb. 7, 1926		43 YRS.				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Virginia	U.S.				Anne Arundel Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis		Anne Arundel Gen. Hospital		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Anne Arundel		Annapolis				468C Boston Hgts. Circle	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
John Barksdale					Mary Adams				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
				Samuel Eades		Annapolis, Md.			HR
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ 431.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Cerebral hemorrhage Hypertension Yes									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
				22a. I certify that (I) (this hospital) attended the deceased from 2/22, 1969, to 2/22, 1969, that (I) (we) last saw the deceased alive on 2/22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
General Church		2/24/69		22e. ADDRESS 121 Cathedral St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2-28-1969		Pine Lawn		Annapolis Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
William Reese		Annapolis, Md.		FEB 26 1969		Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01856		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		01848	
Item 13 Film 409 2/26/69 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH Month Day Year	
Catherine Caline Faux				2 10 69	
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		White		1879 3-27-1883	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (In years lost birthday)	
Pennsylvania		US		85 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		9. COUNTY OF DEATH	
Crownsville		Crownsville State Hospital		Anne Arundel Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		12b. KIND OF BUSINESS OR INDUSTRY	
unknown Md.		unknown			
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
unknown		unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address	
unknown		217-14-2190		Hospital Records, Crownsville State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>pneumonia</u>					
4409 DUE TO, OR AS A CONSEQUENCE OF					
(b) <u>malnutrition</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <u>A.S.V.D.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
<u>Diabetes mellitus - Decubitus ulcers</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/27, 19 68</u> to <u>2/10, 19 69</u> , that (I) (we) last saw the deceased alive on <u>2/10, 19 69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Alberto Gonzalez</u>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) Alberto Gonzalez, M.D. m				22e. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		2-22-1969		Druid Ridge Cemetery	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	
Wm. Cook-Brooks Towson 1050 York Road 21204				DATE FEB 21 1969	
				25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

-55-

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-22-

cc-0 - Top Secret - FRODO BAGGINS

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6 Film G110 3/5/68 Items 18 & 22 01857										MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01849									
1. DECEASED NAME (Type or Print) STACEY L. FURST										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 2 Day 22 Year 1969 2b. HOUR 7:50 P.M.									
3. SEX Female		4. RACE White		5. DATE OF BIRTH 7/1/66		6. AGE (in years last birthday) 32 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0		2c. DATE PRONOUNCED DEAD Month February Day 22 , Year 1969 2d. HOUR 7:50 P.M.							
7a. BIRTHPLACE (State or foreign country) MD.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH ANNE ARUNDEL Md.							
10. CITY OR TOWN OF DEATH Annapolis				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY BALTIMORE				13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1014 Middlesix Road							
14. FATHER'S NAME First ROBERT Middle FURST Lost						15. MOTHER'S MAIDEN NAME First JUDITH Middle CLARK Lost													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. —		17. INFORMANT ROBERT FURS				ADDRESS ABOVE									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7439 IMMEDIATE CAUSE (a) Death during apparent seizure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital malformation of brain DUE TO, OR AS A CONSEQUENCE OF (region of fourth ventricle) (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED February 24, 1969											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 2/26/69		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH				23d. LOCATION (City or Town) (County) (State) BALTO. MD.									
24. FUNERAL DIRECTOR J. B. CONNELLY SONS ADDRESS 300 MACE						25a. REC'D BY REGISTRAR FEB 26 1969		25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>											

53612

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

01858		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01850	
1. DECEASED NAME (Type or print) WILLIAM H. GARDNER				2a. DATE OF DEATH FEB. Month 4 Day 1969 Year		2b. HOUR 5:40 A	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH APRIL 12, 1915		6. AGE (In years last birthday) 53 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL	
10. CITY OR TOWN OF DEATH GLEN BURNIE, MARYLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY SCHULTE FORD	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN GLEN BURNIE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 7824 Bruton Drive		14. FATHER'S NAME First Middle Last Edgar Joseph Gardner		15. MOTHER'S MAIDEN NAME First Middle Last Lula M. King		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No	
16b. SOCIAL SECURITY NO. -		17. INFORMANT Dolly Gardner - 316 Grosvenor Rd. 21225		Address Cheslyn Rd.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Left Ventricular failure DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) hours.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State 1/20 69 2/4 69			
22a. I certify that (I) (this hospital) attended the deceased from 1/20 1969 , to 2/4 1969 , that (I) (we) last saw the deceased alive on 2/4 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Max C. Frank		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/4/69	
22d. PHYSICIAN'S NAME (Type) MAX C FRANK MD		22e. ADDRESS 1515 E. Ritchie Hwy Glen Burnie Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/6/69		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		23d. LOCATION (City or Town) (County) (State) Glen Burnie Md	
24. FUNERAL DIRECTOR John J. Cowen, Sr. Inc. 901 Holston St.		ADDRESS Balti. Md.		25a. REC'D BY REGISTRAR FEE 6 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

02810

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last John William GIBLIN, Sr.					Month Day Year February 18 1969			1:30 P.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		April 20, 1889		79 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsylvania		U.S.				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis			Anne Arundel Gen. Hospital			RAILROAD		RET	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland Pa.			Annapolis				1215 Ridge Row		
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME, First Middle Last				
John GIBLIN					CATHERINE Quitow				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
No						MRS. MARION WARREN #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACVD - atrial fibrillation</u>									
4124									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHF</u>								4 mon	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>myocardial infarction</u>								4 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>2-18-69</u> , that (I) (we) last saw the deceased alive on <u>2-18-69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
<u>John M. Shipley MD</u>						2-18-69			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
J. M. SHIPLEY						Annapolis Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			2-21-69		CATHEDRAL		Seanton Lacka. Pa.		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
John M. Shipley, Annapolis, Md.						FEB 20 1969		Charles Judge	

VR 45M

15810

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01860

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01852

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year				2b. HOUR	
JAMES LEE GOLDSMITH						2c. DATE PRONOUNCED DEAD Month Day Year				2d. HOUR	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		February 27 1969 5:30 PM			
Male	White	May 9 1932	36 YRS.								
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Ohio		U.S.A.				Anne Arundel Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
FT MEADE			Kinehrough Army Hosp.			Inspector			Kilmer Alum.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Howard		Ellicott City		YES <input type="checkbox"/> NO <input type="checkbox"/>		Ellicott City		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Fred W. Goldsmith Sr.			Florence Smith								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
YES			?			Fred W. Goldsmith Sr.			152 E. Ed Rd 21013 Ellicott City, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			5 P.M. 2 27 19 69			Subject driver in auto-auto collision					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
		Street			B-N Parkway N. of Rt. 232 A. A. Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Edward F. Wilson</i>						M.D.			22b. DATE SIGNED		
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			2/28/69		
Edward F. Wilson, M.D.						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			3-4-69			Good Shepherd			Ellicott City Howard Md.		
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		
Higginbotham-Slack Funeral Home						Ellicott City, Md			MAR 5 1969		
						25b. REGISTRAR'S SIGNATURE					

52810

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01853

1. DECEASED NAME (Type or print) ELIZABETH L. GOTT		2a. DATE OF DEATH Month 2 Day 23 Year 69		2b. HOUR A M
3. SEX F	4. RACE W	5. DATE OF BIRTH 9-18-1867	6. AGE (In years last birthday) 101 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) S.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ANNE ARUNDEL Md.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5 TANEX AVE	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOMEWIFE	12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD.	13b. COUNTY A.H.	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 5 TANEX AVE.
14. FATHER'S NAME First Middle Last ALBERT MORDECAI	15. MOTHER'S MAIDEN NAME First Middle Last UNK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Address MRS. J. KENSSETT PYLES #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		
21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1966 , to 2/23, 1969 , that (I) (we) last saw the deceased alive on 2/20, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Richard I. Hochman, M.D.		22c. DATE SIGNED 2/24/69		
22d. PHYSICIAN'S NAME (Type) Richard I. Hochman M.D.		22e. ADDRESS 16 Murray Ave. Annapolis. Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-25-69	23c. NAME OF CEMETERY OR CREMATORY MANCRAFT	23d. LOCATION (City or Town) (County) (State) Beltsville Mont. MD.
24. FUNERAL DIRECTOR John M. Lytle & Sons Annapolis, Md.		25a. REC'D BY REGISTRAR DATE FEB 27 1969		
25b. REGISTRAR'S SIGNATURE [Signature]				

1. Name of deceased: [illegible]

2. Date of death: [illegible]

3. Place of death: [illegible]

4. Cause of death: [illegible]

5. Name of physician: [illegible]

6. Name of informant: [illegible]

7. Signature of informant: [illegible]

8. Signature of physician: [illegible]

9. Signature of registrar: [illegible]

10. Date of registration: [illegible]

11. Place of registration: [illegible]

12. Name of registrar: [illegible]

13. Signature of registrar: [illegible]

14. Date of registration: [illegible]

15. Place of registration: [illegible]

16. Name of registrar: [illegible]

17. Signature of registrar: [illegible]

18. Date of registration: [illegible]

19. Place of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1514
30M REV. 1-54

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
RITA SMUCK GREEN						Month Day Year FEBRUARY 26, 1969			M
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS
Female	White		April 17, 1895			73 YRS.			IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.
Maryland	U.S.A.					Anne Arundel			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Brooklyn			6043 Ritchie Hgwy.			Housewife			Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER
Maryland			Anne Arundel			YES			6043 Ritchie Hgwy.
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William H. Smuck			Freesman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
No						Mrs. Albert Gischel 6048 Ritchie Hgwy. 21225			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction Aorta</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 10 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this-hospital) attended the deceased from June 6, 1959, to Feb 26, 1969, that (I) (we) last saw the deceased alive on 2-26-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Benjamin Berdann</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 2/27/69				
22d. PHYSICIAN'S NAME (Type) Dr. Benjamin Berdann					22e. ADDRESS 615 Hammonds Lane Baltimore, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		March 1, 1969		Holy Cross			Anne Arundel Co., Md.		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
George J. Gonce 4001 Ritchie Hgwy. 21225					DATE MAR 3 1969		Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
01863										01855	
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Robert Lee GRIFFITH, Sr.								February 28, 1969		8:05P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		Cauc.		October 21, 1899		69 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U. S. A.				Anne Arundel Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Annapolis		Anne Arundel General		MD STATE ROADS		RET					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Maryland		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		61 East Street					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
First Middle Last		First Middle Last									
UNK		UNK									
16a. WAS DECEASED EVER IN U.S. ARMY FORCES? Yes, na, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
No				Margaret L. Griffith #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4339 DUE TO, OR AS A CONSEQUENCE OF (b) Dysphagia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Stroke (Left middle meningeal thrombosis) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 1 month 1 month											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Uremia Right hemiplegia, Aphasia, Chronic urinary infection, Dehydration											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
None											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (did) (did not) attend the deceased from Feb 19, 1969, to Feb 28, 1969, that (I) (was) last saw the deceased alive on Feb. 28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1969 February 28					
Charles W. Kinzer											
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Charles W. Kinzer, M. D.		16 Murray Ave., Annapolis, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		3-4-69		Mt. Zion		Lothian An. Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John M. Lystar		Annapolis, Md.		DATE MAR 7 1969		Charles Judge					

11225

11225

REPUBLIC OF DENMARK

REPORT OF THE DANISH DELEGATION TO THE UNITED NATIONS CONFERENCE ON THE LAW OF THE SEA

Submitted to the Conference on the Law of the Sea, Geneva, 1958

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FOR STATE HEALTH DEPT

Any delay in filing this certificate should be executed within 24 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.

M.D. 01864										M.D. 01856											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) BENJAMIN					First (Ben) Middle Last GROSSMAN					2a. DATE KNOWN <input checked="" type="checkbox"/> Month 2 Day 11 Year 1969					2b. HOUR A M						
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 10-7-1912		6. AGE (In years last birthday) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 2 Day 11 Year 1969					2d. HOUR A M				
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Anne Arundel CO Md.						
10. CITY OR TOWN OF DEATH Glen Burnie					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 501 North ARUNDEL HOSP.					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CHEF					12b. KIND OF BUSINESS OR INDUSTRY CATERING						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND COUNTY 13b. COUNTY					13c. CITY OR TOWN BALTIMORE					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER FRANKLIN HOTEL						
14. FATHER'S NAME First JACOB Middle GROSSMAN Last					15. MOTHER'S MAIDEN NAME First CLARA X Middle KRAMER Last																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES					16b. SOCIAL SECURITY NO. W.W. II ARMY					17. INFORMANT 1902 CAREY BRANCH DRIVE MISS SUE ANNE GROSSMAN, WASHINGTON, D.C. 20022											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compressed Fracture Skull DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																					
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY Month, Day, Year 2-11 1969 P.M.					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Auto struck Souther Avenue											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway					21f. LOCATION Street or R.F.D. No. new Cent. Road City or Town ARY County MD State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE E. Linhardt M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					22b. DATE SIGNED 2-11-69											
EXAMINER'S NAME (Type) E. Linhardt					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					ADDRESS (Street, city, town, or county) A. DCU											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE 2-14-69					23c. NAME OF CEMETERY OR CREMATORY MOSES MONTIFIORE											
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD					25a. REC'D BY REGISTRAR FEB 17 1969					25b. REGISTRAR'S SIGNATURE [Signature]											

05824

2000

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2101-5-01 373

• **WILLIAMS**

• • •

JACOB

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

01865										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01857									
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR														
IRENE					CAROL GRUNTOWICZ					FEBRUARY 11 1969					2020 M														
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
FEMALE			CAUCASIAN			17 MAY 1912			56 YRS.			MONTHS DAYS			HOURS MIN														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
WISCONSIN			U. S.						ANNE ARUNDEL Md.																				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
ANNAPOLIS					NAVAL HOSPITAL					HOUSEWIFE																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER									
MARYLAND					ANNE ARUNDEL					ANNAPOLIS					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					RT 1 EPPING FORREST RD.									
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																								
HARRY LARSEN					JULIA																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address														
NO					219 16 18 43					ADAM GRUNTOWICZ					RT 1 EPPING FORREST RD.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION																													
4109 DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																													
(b) ARTERIOSCLEROTIC HEART DISEASE																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from Feb. 11, 1969, to Feb. 11, 1969, that (I) (we) last saw the deceased alive on Feb. 11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE															22c. DATE SIGNED														
22d. PHYSICIAN'S NAME (Type) J. B. CLOSSON, LCDR MC USN															22e. ADDRESS NAVHOSP, ANNAPOLIS, MARYLAND 21402														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					Feb. 15, 1969					Hillcrest Cemetery					Annapolis A.A. Md.														
24. FUNERAL DIRECTOR Beverly E. Hopping															25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE									
HOPPING FUNERAL HOME - Annapolis, Md.															FEB 17 1969														

01821

01821

CERTIFICATE OF DEATH

Age

Sex

Color

Religion

Marital

Place of Birth

Occupation

Education

Service

Place of Death

Cause of Death

Time of Death

Signature

Witness

Physician

Medical Examiner

Signature

Witness

Signature

Witness

NOTARY PUBLIC
My Comm. Expires
Notary Seal - 01821

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01858

1. DECEASED-NAME (Type or print) <i>William</i> First Middle Last <i>Guise</i>			2a. DATE OF DEATH <i>2</i> Month <i>23</i> Day <i>69</i> Year		2b. HOUR <i>5:45</i> AM
3. SEX <i>MALE</i>		4. RACE <i>white</i>	5. DATE OF BIRTH <i>9/15/1908</i>		6. AGE (In years last birthday) <i>60</i> YRS.
7a. BIRTHPLACE (State or foreign country) <i>Pg.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i> Md.
10. CITY OR TOWN OF DEATH <i>Edgewater</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>P.O. Box 312 Edgewater</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>ret. carpenter</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>		13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Edgewater</i>	
14. FATHER'S NAME First <i>Jack</i> Middle Last <i>Guise</i>		15. MOTHER'S MAIDEN NAME First <i>Esther</i> Middle Last <i>Shively</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>NO</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>197-03-6299</i>		17. INFORMANT <i>13204 B. Adams more Beltsville, Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> <i>492x</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Auricular Fibrillation.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Emphysema.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Cirrhosis of liver</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>one year</i> <i>2 years</i> <i>years</i>
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>—</i>	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>—</i>		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (his hospital) attended the deceased from <i>Feb</i> , 19 <i>68</i> , to <i>Feb 23</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2/22/69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Charles H. Wirth MD</i>		22c. DATE SIGNED <i>2/23/69</i>		22d. PHYSICIAN'S NAME (Type) <i>Charles H. Wirth MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal - Burial</i>		23b. DATE <i>2/26/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>All Saints Lutheran Cem.</i>	
24. FUNERAL DIRECTOR <i>Hopping Funeral Home</i>		25a. REC'D BY REGISTRAR <i>FEB 25 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				CERTIFICATE OF DEATH				01859			
1. DECEASED-NAME (Type or print) Corsina				First NMN Middle HALL Last				2a. DATE OF DEATH Month February Day 11 Year 1969				2b. HOUR 7:30 P. M			
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH Jan. 28, 1915				6. AGE (In years lost birthday) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.									
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital Domestic				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) 				12b. KIND OF BUSINESS OR INDUSTRY 					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? XX YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1165 Madison St. Apt. 83							
14. FATHER'S NAME Reese		First NMN Middle Duckett Last		15. MOTHER'S MAIDEN NAME Martha				First NMN Middle Simms Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		(If yes give war or dates of service) *****		16b. SOCIAL SECURITY NO. 216-22-2920		17. INFORMANT Mrs Clarissa Booze Address 1837 Anna Gardens									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 1970 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) 				21f. LOCATION Street or R.F.D. No. City or Town County State 									
22a. I certify that (I) (this hospital) attended the deceased from 2/10, 1969 , to 2/11, 1969 , that (I) (we) last saw the deceased alive on 2/11, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Richard I. Hochman, M.D.		22c. DATE SIGNED 2/11/69		22d. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D. 22e. ADDRESS 16 Murray Ave., Annapolis, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-15-1969		23c. NAME OF CEMETERY OR CREMATORY Pinelawn Memorial Pk				23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md							
24. FUNERAL DIRECTOR C.E. Hicks		ADDRESS 111 43-45 Northwest St		25a. REC'D BY REGISTRAR FEB 18 1969		25b. REGISTRAR'S SIGNATURE 									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) James			First D. Middle Hames Last			2a. DATE OF DEATH 2 Month 28 Day 69 Year		2b. HOUR 1:40AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3-1-20		6. AGE (In years lost birthday) 48 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A.Co. Md.				
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) North Arundel Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death) Maryland			13b. COUNTY A.A.Co.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 1023 Phillip Drive	
14. FATHER'S NAME First Holin Middle Hames Last			15. MOTHER'S MAIDEN NAME First Eva Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) Yes WW 2			16b. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Myrtle Hames, same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hours		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Acute Left Ventricular Failure										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 2-26- , 19 69 , to 2-28- , 19 69 , that (I) (we) last saw the deceased alive on 2-28 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Hilary T. O'Herlihy					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-28-69			
22d. PHYSICIAN'S NAME (Type) Hilary T. O'Herlihy M.D.					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2 March 69		23c. NAME OF CEMETERY OR CREMATORY Little River Cemetery		23d. LOCATION (City or Town) (County) (State) Woodstock, Cherokee, Ga.				
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md. 21061					25a. BY REGISTRAR MAR 4 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

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...A.A.

1st Lt. John J. ... 1st Lt. ...

May 1961

Great Northern Express

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U.S. GOVERNMENT PRINTING OFFICE: 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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01869

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01861

1. DECEASED-NAME (Type or print) Verrell M. Hamilton			2a. DATE OF DEATH Month 2 Day 18 Year 69			2b. HOUR 7:00 AM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH 12-29-85		6. AGE (In years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housework (ret.)			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 204 Delmont Road		
14. FATHER'S NAME First Middle Last James A. Hamilton			15. MOTHER'S MAIDEN NAME First Middle Last Sally Hamilton								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Mrs. Margaret Ringgold Same As #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute MI 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Cerebrovascular DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1/27 , 19 67 , to 2/18 , 19 69 , that (I) (we) last saw the deceased alive on Feb 20, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Febeus Grunberg, M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/18/69			
22d. PHYSICIAN'S NAME (Type) Febeus Grunberg, M.D.						22e. ADDRESS 1113 Old Odonton Road, Odonton, Md. 21113					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Feb. 20, 1969		23c. NAME OF CEMETERY OR CREMATORY London Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR R. Singleton			25a. RECD BY REGISTRAR Singleton Funeral Home			25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 19 1969			

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MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
CERTIFICATE OF DEATH																							
1. DECEASED-NAME (Type or print)			First ALICE			Middle E.			Last HANCE			2a. DATE OF DEATH Month 2			Day 1			Year 1969			2b. HOUR 5:50 A.M.		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 1/21/84			6. AGE (In years lost birthday) 85 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE (State or foreign country) Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ANNE Arundel Md.														
10. CITY OR TOWN OF DEATH Crownsville, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Calvert Co			13c. CITY OR TOWN Prince Frederick			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER —											
14. FATHER'S NAME First Thomas			Middle WEEMS.			Last —			15. MOTHER'S MAIDEN NAME First ROSE			Middle BOWEN			Last —								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO			16b. SOCIAL SECURITY NO. 220-24-9210-J			17. INFORMANT Claude Hance			Address Millersville, Md.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 486x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u>																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerotic cardiovascular disease. Uremia. Malnutrition</u>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from Jan 23, 1969, to Jan 31, 1969, that (I) (we) last saw the deceased alive on Jan 31, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE Nick P. Moutsos												DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (Type) NICK P. MOUTSOS												22e. ADDRESS Crownsville State Hosp. Crownsville, Md 21032											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE Feb. 3, 1969			23c. NAME OF CEMETERY OR CREMATORY Ashbury Cemetery			23d. LOCATION (City or Town) (County) (State) Barnes, Calvert, Md.														
24. FUNERAL DIRECTOR A. G. Harkness, Son, Fort Republic, Md.												25a. REC'D BY REGISTRAR DATE FEB 4 1969			25b. REGISTRAR'S SIGNATURE Charles O. ...								

91801

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CRIMINAL RECORDS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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01871				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01863			
1. DECEASED-NAME (Type or print)				First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR	
Robert				E		Hastings	Month	Day	Year	6 ⁰⁰ A M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male		White		7-17-88			80 YRS.		MONTHS	DAYS	HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				ANNE ARUNDEL Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Glen Burnie		NORTH ARUNDEL Hospital		Retired		Md. State Roads					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		ANNE ARUNDEL		Glen Burnie				#200 Chain Hwy., S.W.			
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost		
(Unknown)				Hastings	Rachael				(Unknown)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		227-14-5349		Mrs. Amy P. Hastings (wife)		Same As #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Thrombosis of Rt Middle Cerebral Artery</u>										9 days	
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Cerebro Vascular Disease</u>										year	
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Generalized Arteriosclerosis</u>										year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
<u>Arteriosclerosis of Heart Disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>2-7-69</u> , 19 <u>69</u> , to <u>2-16-69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2-15-69</u> , 19 <u>69</u> ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>Hilary T. O'Hertly, M.D.</u>						<input checked="" type="checkbox"/>				<u>2-16-69</u>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
<u>Hilary T. O'Hertly, M.D.</u>				<u>Hospital Drive, Glen Burnie, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town)		(County)		(State)	
<u>Cremation</u>		<u>Feb. 19, 1969</u>		<u>London Park</u>		<u>Balto.</u>		<u>Md.</u>			
24. FUNERAL DIRECTOR				25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<u>R. Singleton</u>				<u>Singletons Funeral Home</u>		<u>Glen Burnie, Maryland</u>		<u>FEB 19 1969</u>			

Mr. [illegible]

2500 [illegible] [illegible]

(Unknown)

Rachel

Hastings

(Unknown)

2500 [illegible] [illegible]

2500 [illegible] [illegible]

No

2500 [illegible] [illegible]

2500 [illegible] [illegible]

2500 [illegible] [illegible]

2500 [illegible] [illegible]

2500 [illegible] [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

VR A151
30M REV 1/78

<div style="display: flex; justify-content: space-between;"> 01872 MARYLAND STATE DEPARTMENT OF HEALTH 01864 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>																	
1. DECEASED-NAME (Type or print)			First Edith			Middle Hawkins			Last			2a. DATE OF DEATH Month 2 Day 5 Year 69			2b. HOUR 12:50a		
3. SEX Female			4. RACE Negro			5. DATE OF BIRTH 5/15/08			6. AGE (In years lost birthday) 60 YRS.			IF UNDER 1 YEAR MONTHS 0			IF UNDER 24 HRS. DAYS 0		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? US			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.								
10. CITY OR TOWN OF DEATH Crownsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland			13b. COUNTY Balto			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 203 Durham Street					
14. FATHER'S NAME First Isaac Middle Fisher Last Fisher			15. MOTHER'S MAIDEN NAME First Elisa Middle Elisa Last Elisa														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <input checked="" type="checkbox"/> unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. unknown			17. INFORMANT Hospital Records, Crownsville, Maryland Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure - 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) A-S-V-D. DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Infected Peritonsillar cyst - Diarrhea Syndrome -																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 1/10 , 19 66 , to 2/5 , 19 69 , that (I) (we) last saw the deceased alive on 2/5 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Alberto Gonzalez			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 2/5/69								
22d. PHYSICIAN'S NAME (Type) Alberto Gonzalez, M.D.			22e. ADDRESS Crownsville State Hospital, Maryland														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2-11-69			23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cem.			23d. LOCATION (City or Town) (County) (State) Baltimore Md.								
24. FUNERAL DIRECTOR E. O. Walaun			ADDRESS 1000 Bentley Rd.			25a. REC'D BY REGISTRAR DATE FEB 10 1969			25b. REGISTRAR'S SIGNATURE Charles Judge								

MEDICAL CERTIFICATION

2810

07619

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01873

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01865

1. DECEASED-NAME (Type or print) First Middle Last Frank A. Hermans			2a. DATE OF DEATH Month Day Year 2-8-69		2b. HOUR 5 PM
3. SEX M	4. RACE W	5. DATE OF BIRTH Nov 28, 1878		6. AGE (In years) Months Days 90	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) N.Y.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH A.A. Co. Md.		
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Boys Monod nee		12a. USUAL OCCUPATION (Kind of work done during most of working life or at death) ENGINEER	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY Cal. City - Balto.	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3812 GLENMORE AVE.
14. FATHER'S NAME First Middle Last Franklin HERMANS		15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth DOCKSTADTER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 42 East St. ANNAPOLIS, MD.		17. INFORMANT Dahly N. Schalible	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden V.C.V.D. 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 11-11-68 to 2-8-69 , that (I) (we) last saw the deceased alive on 2-3-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Robert R. Halin				22c. DATE SIGNED 2-8-69	
22d. PHYSICIAN'S NAME (Type) Robert R. Halin				22e. ADDRESS P.O. Box 738	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2/11/69		23c. NAME OF CEMETERY OR CREMATORY OAK WOOD CEM	
24. FUNERAL DIRECTOR John M. Lathrop		ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR FEB 14 1969	
25b. REGISTRAR'S SIGNATURE [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01874

CERTIFICATE OF DEATH

01866

1. PLACE OF DEATH o. COUNTY AA Co MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md b. COUNTY AA Co			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 344 Rt 2 Glen Burnie				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle A Last Higdon				4. DATE OF DEATH Month Feb Day 17 Year 1969			
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15 1891	9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James R Higdon				14. MOTHER'S MAIDEN NAME Minnie Dear			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family Address Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma of the Lung DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from July 2, 1968 , to Dec. 9, 1968 , that (I) (we) last saw the deceased alive on December 9, 1968 , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE J. Kemper Owens M.D.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS				22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/21/69		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Balto Co Md	
24. FUNERAL DIRECTOR McCully H.		ADDRESS 237 Patapsco Ave.		25a. FEB 24 1969		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
01875									
01867									
1. DECEASED-NAME (Type or print) Kathryn Regan Higgins			2a. DATE OF DEATH Feb. 11 1969			2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH Jan. 7, 1901		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Millersville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Knottwood Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U.S. Gov't.		12b. KIND OF BUSINESS OR INDUSTRY Civil Service			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Eppingerforest		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rte. 1, Box 501	
14. FATHER'S NAME First Middle Last Edwin Regan			15. MOTHER'S MAIDEN NAME First Middle Last 'Yuk'						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO.		17. INFORMANT Eugene E. Higgins		Address #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 5192 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive Pulmonary disease 1 day DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) arteriosclerotic Cardiovascular disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Rm Smith				DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Feb 11, 1969			
22d. PHYSICIAN'S NAME (Type) R M Smith				22e. ADDRESS SEVERNA PARK MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-14-1969		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City or Town) (County) (State) Washington D.C.			
24. FUNERAL DIRECTOR John M. Saylor & Sons				ADDRESS Chnapols, Md.		25. REC'D BY REGISTRAR FEB 14 1969		25b. REGISTRAR'S SIGNATURE	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01876		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01868					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
JAMES		PUTNAM		HOWELL				Month 2		Day 15	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
M		W		12-2-75		93 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
VA.		USA				ANNE ARUNDEL					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
ANNAPOLIS		ANNE ARUNDEL GEN HOSP		RET							
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		ANNE ARUNDEL		SHADYSIDE							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First	
FRANK		HOWELL		VIRGINIA		AKERS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No (or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		226-32-5127		Gladys Riley		Shady Side, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		PULMONARY EDEMA, ACUTE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
514X		DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF							
		(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
2-10-69		FRACTURE OF HIP		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 2-7-69, 1969, to 2-15-69, 1969, that (I) (we) last saw the deceased alive on 2-15-69, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Richard F. Marshall MD		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-26-69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		2/19/69		Woodfield		Galesville AA Md					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Hardesty		Funeral Home, Galesville, Md		DATE		MAR 11 1969		Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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45M - 1-69

01877										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01869																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First Middle Last										Month Day Year										M																													
3. SEX Male										4. RACE White										5. DATE OF BIRTH 9 Jan. 1883										6. AGE (In years last birthday) YRS. MONTHS DAYS HOURS MIN.																			
7a. BIRTHPLACE (State or foreign) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Anne Arundel Md.																			
10. CITY OR TOWN OF DEATH Glen Burnie										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hosp.										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) operator										12b. KIND OF BUSINESS OR INDUSTRY Davison Chem																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland										13b. COUNTY A.A.Co.										13c. CITY OR TOWN Glen Burnie										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER 7th St. RFD.2 Box 266									
14. FATHER'S NAME First Middle Last Henry Hyson										15. MOTHER'S MAIDEN NAME First Middle Last (unknown) Frick										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If yes give war or dates of service) no										16b. SOCIAL SECURITY NO. 215-07-7935										17. INFORMANT Address William Hyson - Glen Burnie, Maryland									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Left ventricular Cardiac rupture</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from <u>4/13</u> , 19 <u>62</u> , to <u>1/17</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/15</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <u>G. S. Linsao, M.D.</u> DEGREE										22c. DATE SIGNED 2/17/69																													
22d. PHYSICIAN'S NAME (Type) G.S. Linsao, M.D.										22e. ADDRESS 1308 Farnace Branch Rd. Glen Burnie, Md. 21061										22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>																													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 2/19/69										23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk. Glen Burnie, Maryland										23d. LOCATION (City or Town) (County) (State)																			
24. FUNERAL HOME Robert P. Ware										24b. ADDRESS 77 Glen Burnie, Md.										25a. REC'D BY REGISTRAR FEB 18 1969										25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>																			

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MYSON, DR.

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Henry

DR

9 Jan. 1953

White

Male

Anna Alexander

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U.S.

Mythian

Davidson

Operator

Walter Albert Wood

Glen Morris

W. J. S. W.D.S. Box 200

Glen Morris

W.A.C.

Mythian

Flux

(Unknown)

Hyson

Henry

----- 215-03-2955 William Hyson - Glen Morris, Mythian

2/19/53 Glen Haven Hospital, K. Glen Morris, Mythian

2/19/53 Glen Morris, W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Edward L. Johnson					2a. DATE OF DEATH 2 Month 27 Day 69 Year			2b. HOUR 4:40A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11-13-97			6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A.Co.			
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Contractor			12b. KIND OF BUSINESS OR INDUSTRY Retired
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death) Maryland			13b. CITY OR TOWN Millersville			13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO			13d. STREET AND NUMBER Box 307 Rt. 1
14. FATHER'S NAME First Thomas Middle B. Last Johnson					15. MOTHER'S MAIDEN NAME First Harriet Middle M. Last Linthicum				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. 217-34-3718		17. INFORMANT Address Mrs. Georgia B. Johnson, same as 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA & Coma 4329 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carotid Artery Insufficiency (c) General Arteriosclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Thrombosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2-14 , 19 69 , to 2-27 , 19 69 , that (I) (we) last saw the deceased alive on 2-26 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE D. Dorkan					DEGREE MD. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-27-69		
22d. PHYSICIAN'S NAME (Type) Cenap S. Dorkan M.D.					22e. ADDRESS 325 Hospital Drive, Glen Burnie				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3 March 69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, AA Co., Md.			
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.					25a. RECEIVED BY REGISTRAR FEB 28 1969		25b. REGISTRAR'S SIGNATURE		

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01878

Johnson, L. L. 11-1-37 17

White, J. 11-1-37 17

U.S.A. 11-1-37 17

North Atlantic Hospital, 11-1-37 17

Box 107 11-1-37 17

Johnson, L. L. 11-1-37 17

Johnson, L. L. 11-1-37 17

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VR A15-14
45M - 1-68

01879		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01871					
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M		
ETHEL				SOULE	JOHNSON	FEBRUARY 13 1969			1040		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
FEMALE		CAUCASIAN		4 FEBRUARY 1912		57 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U. S.				ANNE ARUNDEL Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
ANNAPOLIS		NAVAL HOSPITAL		HOUSEWIFE		HOME					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		ANNE ARUNDEL		ANNAPOLIS				214 PROVIDENCE ROAD			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
CARLTON				"M"	SOULE	ETHEL					WOODROW
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT			Address		
NO				217 58 18 60		RALPH C. JOHNSON			# 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOLOSCLEROTIC CARDIO VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 13 FEBRUARY 1969, to 13 FEBRUARY 1969, that (X) (we) last saw the deceased alive on 13 FEBRUARY 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jon B. Closson, MD.					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 14 FEB 1969		
22d. PHYSICIAN'S NAME (Type) JON B. CLOSSON, LCDR MC USN					22e. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		2/17/1969		US Naval Academy Cem		ANNAPOLIS MD.					
24. FUNERAL DIRECTOR JOHN M. TAYLOR SONS ANNAPOLIS MD.					ADDRESS		25a. REC'D BY REGISTRAR FEB 18 1969		25b. REGISTRAR'S SIGNATURE		

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CHURCH OF DEATH

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CHURCH OF DEATH

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MEDICAL CERTIFICATION

1. DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH				2b. HOUR	
MATILDA						JOHN	Month	Day	Year			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
female		white		June 25, 1880			88 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Norway		U. S. A.					Anne Arundel Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore, Md. 21226			none			housewife			Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Anne Arundel			Baltimore		YES		200 Greenland Beach Rd.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
Olsen			Bjorge			Martha			Olsen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
no			217-48-7220			Mrs. Hilz Tulson			same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation											2 years	
4123 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerotic heart disease											3 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
none												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from November 1, 1965, to Feb. 26, 1969, that (I) (we) last saw the deceased alive on Feb. 24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE R. M. McLaughlin, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED 2/26/69												
22d. PHYSICIAN'S NAME (Type) R. M. McLaughlin 22e. ADDRESS 3708 Mountain Road, Pasadena, Md.												
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			3-1-69		Glen Haven			Anne Arundel Co., Md.				
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
George J. Gonce 4001 Ritchie Highway 21225						MAR 3 1969		Charles Judge				

01840

01840

REPUBLIC OF DENMARK

[Faint, mostly illegible text across the page, possibly bleed-through from the reverse side. Some words like "REPUBLIC OF DENMARK" and "01840" are visible.]

MAR 2 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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01881		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01873	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) Frank C Kallross			First Middle Last		2a. DATE OF DEATH Month Day Year 2-11-69		2b. HOUR 3:30 PM
3. SEX M	4. RACE W		5. DATE OF BIRTH 11-03-89		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) md		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A. Co Md.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) AA Gen Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Bricklay	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE md		13b. COUNTY AA		13c. CITY OR TOWN ARNO		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER RT 3 Box 311		14. FATHER'S NAME First Middle Last Kallross		15. MOTHER'S MAIDEN NAME First Middle Last Minnie Kallross			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. no		17. INFORMANT Minnie Kallross		Address alone	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1957 , 19____, to 1969 , 19____, that (I) (we) last saw the deceased alive on 2-11-69 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert R. Hoban		22c. DATE SIGNED 2-11-69		22d. PHYSICIAN'S NAME (Type) Robert R. Hoban		22e. ADDRESS P.O. Box 73	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/15/69		23c. NAME OF CEMETERY OR CREMATORY Meadowridge		23d. LOCATION (City or Town) County State Dorsey, Prince Georges	
24. FUNERAL DIRECTOR Robert S. Banamco		25a. REC'D BY REGISTRAR Severna Park, Md		25b. REGISTRAR'S SIGNATURE Robert S. Banamco		DATE FEB 14 1969	

MEDICAL CERTIFICATION

[illegible]

6-11-5

Robert

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

01882				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01874							
1. DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH Month Day Year				2b. HOUR a M	
Edith				Pearl		Kelly		Feb. 11, 69				10 ⁴⁵ a M			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.			
Female		White		23 Apr. 1891				77 YRS.							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.			
Maryland		USA				Anne Arundel									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY									
Glen Burnie		North Arundel Conv. Center		Housewife		Own Home									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER							
Md.		AA		Glen Burnie				1208 Guilford Road							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
William		D.		Mewshaw				Eliza		R.		Donaldson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address							
no				214-14-4434		Mrs. Violet Broseker, same as 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left ventricular failure</u>														Hours	
2509 DUE TO, OR AS A CONSEQUENCE OF <u>Uremia</u>														Days	
(b) <u>Diabetes Mellitus</u>														Years	
(c) <u>Generalized arteriosclerosis</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
<u>Generalized arteriosclerosis</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION		Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/5/69</u> , 19 <u>69</u> , to <u>2/11/69</u> , 19 <u>69</u> , that (I) (we) lost the deceased alive on <u>2/11/69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE				DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>Max Frank</u>														12 Feb. 69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS											
Max Frank, M. D.				Arundel Medical Group, Glen Burnie, Md											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)		(County)		(State)			
Burial		14 Feb. 69		Glen Haven Memorial Park				Glen Burnie, AA, Md.							
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Kirkley Funeral Home, Glen Burnie, Md.								DATE		FEB 13 1969					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
Catherine Kennedy					2 24 69		1:00 PM	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years lost birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	Caucasian	11/18/89			79 YRS.	MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland	USA			Anne Arundel Md.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Crownsville	Crownsville State Hospital			Sales Lady				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Maryland	Baltimore	Baltimore			1200 Valley			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
Peter H Kennedy					Margaret Elwood			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT				
b no		219-07-4409		Hospital Records, Crownsville State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Pulmonary emphysema, Moderate</u>								
4124 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
(b) <u>Focal bronchopneumonia, basal, bilateral</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c) <u>Arteriosclerotic cardio vascular disease</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
<u>Hemorrhagic cystitis</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>1/21</u> , 19 <u>69</u> , to <u>2/24</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/24</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Charles R. Venter, M.D.</u>						22c. DATE SIGNED 2/24/69		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS		
Charles R. Venter, M.D.						Crownsville State Hospital, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		2/27/69		New Cathedral		Baltimore, Maryland		
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
Leonard J Ruck Inc. Baltimore, Maryland				FEB 25 1969		<u>Charles Judge</u>		

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TABLE 1

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Dr. J. H. ...

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1013. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01884

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01876

1. DECEASED-NAME (Type or Print) <i>William Edward King Jr</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>2</i> Day <i>13</i> Year <i>69</i>			2b. HOUR <i>P</i>						
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>2-27-11</i>	6. AGE (In years last birthday) <i>57</i> YRS.	IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>	IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>	2c. DATE PRONOUNCED DEAD Month <i>2</i> Day <i>13</i> Year <i>69</i>			2d. HOUR <i>P</i>			
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel Co</i>						
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Don North ARUNDEL Hosp</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Foreman</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Penn-Sent R.R.</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Odenton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Rt. #1 - Box #361 A</i>			
14. FATHER'S NAME First <i>W. Edward</i> Middle <i>King</i> Last <i>St.</i>			15. MOTHER'S MAIDEN NAME First <i>Annie</i> Middle <i>Tucker</i> Last <i></i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>717-09-3680</i>		17. INFORMANT <i>Mrs. Hazel G. King (wife)</i>			ADDRESS <i>Same As #13</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>atherosclerotic cardiovascular disease</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Chosen</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <i>19</i> HOUR A.M. <i></i> P.M. <i></i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>[Signature]</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E. Linhart Jr.</i>			ADDRESS (Street, city, town, or county) <i></i>			22b. DATE SIGNED <i>2/13/69</i>			<i>A.A. Co.</i>			
23a. BURIAL, CREMATION, OR OTHER (Specify) <i>Burial</i>			23b. DATE <i>Feb. 17, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Park</i>			23d. LOCATION (City or Town) <i>Glen Burnie, Md.</i> (County) <i></i> (State) <i></i>				
24. FUNERAL DIRECTOR <i>R. V. Singleton</i>			ADDRESS <i>Singleton Funeral Home, Glen Burnie, Md.</i>			25a. REC'D BY REGISTRAR <i></i>			25b. REGISTRAR'S SIGNATURE <i></i>			
DATE <i>FEB 17 1969</i>												

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15-02-2015 15:00 (15:00) 15:00

1. *Handwritten notes and signatures at the bottom of the page, including "Feb. 17, 1907" and "J. V. Smith".*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01885

01877

1. DECEASED-NAME (Type or print) <i>James La Sage</i>			First Middle Last			2a. DATE OF DEATH Month <i>2</i> Day <i>3</i> Year <i>69</i>			2b. HOUR <i>5:50 PM</i>		
3. SEX <i>Male</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>7-30-1889</i>			6. AGE (In years lost birthday) <i>79</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Anne Arundel County</i> Md.		
10. CITY OR TOWN OF DEATH <i>Glen Burnie Md.</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Mary's Hospital 735 S. Fawcett Rd.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Laborer</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>General</i>		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Stent</i>			13c. CITY OR TOWN <i>Millington</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER			14. FATHER'S NAME First Middle Last <i>Andrew LaSage</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Jennie Lee</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <i>No.</i>			16b. SOCIAL SECURITY NO. <i>420-254280</i>			17. INFORMANT Address <i>Mrs. Pearl Bailey, Townsend, Del. 19734</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>unknown</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>12-20</i> , 19 <i>68</i> , to <i>2-3</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2-3-69</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Richard H. Heert</i>									22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) <i>Richard H. Heert</i>									22e. ADDRESS <i>100 Cherry Lane Glen Burnie, A.A. Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (specify) <i>Burial</i>			23b. DATE <i>Feb. 6, 1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Sudlersville Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Sudlersville Q.A. Md.</i>		
24. FUNERAL DIRECTOR ADDRESS <i>Edward Fellows, Millington, Md.</i>						25a. REC'D BY REGISTRAR DATE <i>FEB 7 1969</i>			25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01886

01878

1. DECEASED-NAME (Type or print) Vivian			First M Middle LA VOIE Last			2a. DATE OF DEATH Month February Day 10 Year 1969			2b. HOUR 5:58 A. M		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 1-3-06			6. AGE (In years lost birthday) 63 YRS.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.		
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HAIR DRESSER			12b. KIND OF BUSINESS OR INDUSTRY SELF		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Annapolis			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER 1956 RIVERBAY			13f. CITY OR TOWN Route 6, CAPE ST. CLAIRE			14. FATHER'S NAME First ? Middle ? Last ?			15. MOTHER'S MAIDEN NAME First ? Middle ? Last ?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. —			17. INFORMANT Homer LeChie Address Alboma					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pulmonary emboli, acute 450 X DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb. 5 , 19 69 , to Feb 10 , 19 69 , that (I) (we) last saw the deceased alive on Feb 10 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Rm Smith						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) Ray M. Smith, M.D.						22e. ADDRESS HahnProfBldg., Severna Park, Md.					
23a. BURIAL CREMATION— REMENTAL (Specify)			23b. DATE 2-13-69			23c. NAME OF CEMETERY OR CREMATORY Lanana Park			23d. LOCATION (City or Town) (County) (State) Severna Park, Md.		
24. FUNERAL DIRECTOR Robert S. Benane						ADDRESS Severna Park			25a. BY REGISTRAR FEB 14 1969		
						25b. REGISTRAR'S SIGNATURE [Signature]					

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Don Smith

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01887		01879											
1. DECEASED-NAME (Type or Print)				2a. DATE KNOWN OF DEATH				2b. HOUR					
First		Middle		Last		Month		Day		Year		M	
MOLLIE		Brooks		LEGUM		ESTI- MATED		19					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
female		white		Dec. 25, 1883		1883 YRS.		MONTHS		DAYS		Month Day Year	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		DIVORCED		9. COUNTY OF DEATH		2d. HOUR	
Rumania		USA		WIDOWED		X				Anne Arundel		5:00 P.M.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY							
Annapolis		Anne Arundel Gen. Hosp.		housewife									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Maryland		Anne Arundel		Annapolis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		30 Murray					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle	
Nathan		Schechter						Hanna		L.		Cutler	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
no		217-48-4680J		Miss Rane Brooks - same as #13 above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Multiple Injuries													
DUE TO, OR AS A CONSEQUENCE OF													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
Arteriosclerotic Cardiovascular Disease													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH				UNKP.M. 1/31 19 69				subj. passenger in auto involved in collision					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
				street				Anne Arundel, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED					
EXAMINER'S NAME (Type)				Werner U. Spitz, M.D.				2/18/69					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY					
Burial				2/19/69				United Hebrew Cem. Inc.					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Beverley E. Hopping				FEB 19 1969									
Hopping Funeral Home - Annapolis, Md.													

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1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 23 per telephone call
from F.H. 4/2/69
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01880

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Gorton				Parker	Lindsay	Month 2 Day 24 Year 69			4 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		9/20/14		54 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
unknown		USA				Anne Arundel Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Crownsville			Crownsville State Hospital			Business mgr.			School		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Anne Arundel		Severna Park		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		103 Lockleven Drive		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Isabelle				G.		Mary					Parker
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT						
unknown			215-12-2854		Hospital Records, Crownsville State Hospital						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Cardiac failure											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 2/23, 1969, to 2/24, 1969, that (I) (we) last saw the deceased alive on 2/24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles R. Venter						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 2/24/69		
22d. PHYSICIAN'S NAME (Type) Charles R. Venter, M.D.						22e. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			2/27/69		Shiloh Baptist Ch. Am.			Shiloh Va.			
24. FUNERAL DIRECTOR Robert S. Bananas, Severna Park, Md.						25a. REC'D BY REGISTRAR DATE FEB 27 1969			25b. REGISTRAR'S SIGNATURE William J. Jones		

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CENTRAL BANK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

<div style="display: flex; justify-content: space-between;"> 01889 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01881 </div>											
1. DECEASED-NAME (Type or print) Adelaide C LIVENGOOD						2a. DATE OF DEATH February 2 Day 1969 Year			2b. HOUR 9:07P M		
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH Sept. 6, 1914			6. AGE (In years day birthday) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) DEPT. STORE			12b. KIND OF BUSINESS OR INDUSTRY Credit Dept.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland 13b. COUNTY Anne Arundel			13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 136 Pinecrest Drive				
14. FATHER'S NAME Harry Crytzer				15. MOTHER'S MAIDEN NAME IDA STEEL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown		16b. SOCIAL SECURITY NO. 193 01 2743		17. INFORMANT RAYMOND L. LIVENGOOD Address #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction (c) Coronary arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour several hours several years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus, Hypertension, Obesity											
19a. DATE OF OPERATION NA		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) this hospital attended the deceased from Oct. 10, 1963 , to Feb. 2, 1969 , that (I) have lost saw the deceased alive on February 2, 1969 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) have (did) not view the body after death.											
22b. SIGNATURE Charles W. Kinzer DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED Feb. 3, 1969					
22d. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.						22e. ADDRESS 16 Murray Ave, Annapolis, Md. 21401					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2-5-69		23c. NAME OF CEMETERY OR CREMATORY HILLCREST		23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md.					
24. FUNERAL DIRECTOR John M. Lyford Annapolis Md.						25a. REC'D BY REGISTRAR FEB 7 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
VERNON			DOMINIC			LOVE			Feb. 18, 1969 11:30 AM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
Male			White			June 4, 1904			64 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			U.S.A.						Anne Arundel Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Edgewater			Shoreham Beach			Ret. Mechanic			D.C. Transit		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Md.			Anne Arundel			Shoreham Beach			1402 Schooner Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
John Berry Love			Mary Roseanna E. Knott								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
no			578 10 5542			Helen D. Love			Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of the Liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Cirrhosis of the liver.</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>19 DEC, 1968</u> , to <u>DATE</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>10 Feb</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS		
<u>William H. Choate</u>			18 Feb 1969			William H. Choate, M.D.			Colonial Bk. & Tr. Building Annapolis, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			2/21/69			Ft. Lincoln			Colmar Manor P.G. Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Francis Gasch's Sons Hyattsville Maryland			FEB 24 1969								

28810

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01891

01883

1. DECEASED-NAME (Type or print) MAMIE V. Markberger			First Middle Last			2a. DATE OF DEATH Month Day Year 2-22-69			2b. HOUR 4:39 PM		
3. SEX F		4. RACE W		5. DATE OF BIRTH 10/24/51			6. AGE (In years lost birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Ind		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A. Md.					
10. CITY OR TOWN OF DEATH Millsville Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Millsville Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY A.A.		13c. CITY OR TOWN Severna Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 721 McKensay Rd.		
14. FATHER'S NAME First Middle Last A. Dixon			15. MOTHER'S MAIDEN NAME First Middle Last John Markberger - Upper Marlboro Md.								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, ar, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. —		17. INFORMANT Address John Markberger - Upper Marlboro Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EVA 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) EVA Gen. at DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1957 , 19____, to 1969 , 19____, that (I) (we) lost saw the deceased alive on 2-21-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Robert B. Hahn			22c. DATE SIGNED 2-22-69			22d. PHYSICIAN'S NAME (Type) Robert B. HAHN			22e. ADDRESS Severna Park Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 2/25/69		23c. NAME OF CEMETERY OR CREMATORY Solomon S. Meth Ch. Cnd. Solomon S. Md.			23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR Robert S. Baran, Severna Park Md.			25a. REC'D BY REGISTRAR DATE FEB 26 1969			25b. REGISTRAR'S SIGNATURE Charles Judge					

2587

STATE OF TEXAS

1887

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

01892

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 4 Film G410 3/4/69 kk

CERTIFICATE OF DEATH

01884

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena			c. LENGTH OF STAY IN 1b Pasadena		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1980 Betty Lane 21122			d. STREET ADDRESS 1980 Betty Lane 21122		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First John Middle Truman Last McCleary Sr.			4. DATE OF DEATH Month February Day 24 Year 1969		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 23, 1903	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Standard Lime &	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Charles Truman McCleary			14. MOTHER'S MAIDEN NAME ?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO.	17. INFORMANT Address Mrs. Margaret E. McCleary 1980 Betty Lane 21122		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 coronary occlusion DUE TO (b) hypertensive CV disease DUE TO (c) last					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Nov 1936 , to 2/24 1969 that (I) (we) last saw the deceased alive on 222 1969 , and that death occurred at 4 AM , from causes and on the date stated above.					
22a. SIGNATURE Thompson Keister			22b. DATE SIGNED 2/25/69		
22c. PHYSICIAN'S NAME (Type) KEISTER			22d. ADDRESS 302 Patapsco Ave		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/26/69	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Pk	23d. LOCATION (City or Town) (County) (State) Dorsey Howard Co. Md.		
24. FUNERAL DIRECTOR ADDRESS McCully F. H. 237 Patapsco Ave. 21225			25a. REC'D BY REGISTRAR FEB 27 1969		25b. REGISTRAR'S SIGNATURE [Signature]

41886

UNITED STATES OF AMERICA

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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01893		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01885	
Item 23 Film 409 2/26/69 kk		CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)		First		Middle		Last	
Jerome		McCConnell					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	
male		Negro		12/25/15		7. AGE (In years lost birthday) 53 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
unknown		US				Anne Arundel	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Crownsville		Crownsville State Hospital					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Baltimore		Baltimore		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last					
unknown		unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
unknown		unknown		Hospital Records, Crownsville State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5990 Bronchopneumonia							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) G U tract infection					
		(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
Chronic brain syndrome ; alcoholism							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12/22, 1967, to 2/14, 1969, that (I) (we) lost the deceased alive on 2/14, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Charles R. Venter, M.D.		22c. DATE SIGNED 2/17/69			
22d. PHYSICIAN'S NAME (Type) Charles R. Venter, M.D.		22e. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2-14-69		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR E. W. O. Wilson, Jr.		25a. REC'D BY REGISTRAR FEB 19 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

01885

01883

CERTIFICATE OF DEATH

1. Name of Deceased		2. Date of Death	
3. Place of Death		4. Cause of Death	
5. Age at Death		6. Sex	
7. Marital Status		8. Occupation	
9. Signature of Registrar		10. Signature of Medical Officer	
11. Date of Registration		12. Place of Registration	
13. Name of Registrar		14. Name of Medical Officer	
15. Name of Registrar		16. Name of Medical Officer	
17. Name of Registrar		18. Name of Medical Officer	
19. Name of Registrar		20. Name of Medical Officer	
21. Name of Registrar		22. Name of Medical Officer	
23. Name of Registrar		24. Name of Medical Officer	
25. Name of Registrar		26. Name of Medical Officer	
27. Name of Registrar		28. Name of Medical Officer	
29. Name of Registrar		30. Name of Medical Officer	
31. Name of Registrar		32. Name of Medical Officer	
33. Name of Registrar		34. Name of Medical Officer	
35. Name of Registrar		36. Name of Medical Officer	
37. Name of Registrar		38. Name of Medical Officer	
39. Name of Registrar		40. Name of Medical Officer	
41. Name of Registrar		42. Name of Medical Officer	
43. Name of Registrar		44. Name of Medical Officer	
45. Name of Registrar		46. Name of Medical Officer	
47. Name of Registrar		48. Name of Medical Officer	
49. Name of Registrar		50. Name of Medical Officer	
51. Name of Registrar		52. Name of Medical Officer	
53. Name of Registrar		54. Name of Medical Officer	
55. Name of Registrar		56. Name of Medical Officer	
57. Name of Registrar		58. Name of Medical Officer	
59. Name of Registrar		60. Name of Medical Officer	
61. Name of Registrar		62. Name of Medical Officer	
63. Name of Registrar		64. Name of Medical Officer	
65. Name of Registrar		66. Name of Medical Officer	
67. Name of Registrar		68. Name of Medical Officer	
69. Name of Registrar		70. Name of Medical Officer	
71. Name of Registrar		72. Name of Medical Officer	
73. Name of Registrar		74. Name of Medical Officer	
75. Name of Registrar		76. Name of Medical Officer	
77. Name of Registrar		78. Name of Medical Officer	
79. Name of Registrar		80. Name of Medical Officer	
81. Name of Registrar		82. Name of Medical Officer	
83. Name of Registrar		84. Name of Medical Officer	
85. Name of Registrar		86. Name of Medical Officer	
87. Name of Registrar		88. Name of Medical Officer	
89. Name of Registrar		90. Name of Medical Officer	
91. Name of Registrar		92. Name of Medical Officer	
93. Name of Registrar		94. Name of Medical Officer	
95. Name of Registrar		96. Name of Medical Officer	
97. Name of Registrar		98. Name of Medical Officer	
99. Name of Registrar		100. Name of Medical Officer	

01883

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR 12 00 M		
ROSE CAROLINE MC NAIR						February 20 1969		1400 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
FEMALE		CAUCASIAN		24 December 1883		85 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Pennsylvania		U. S.				ANNE ARUNDEL				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
ANNAPOLIS			NAVAL HOSPITAL			HOUSEWIFE				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ANNE ARUNDEL		ANNAPOLIS		YES		203 MEADOWGATE DRIVE	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
FREDERICK DEAGLE			Dorothy unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
NO			267-728-968		CHARLES F. MCNAIR, 203 MEADOWGATE DRIVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PELVIC ABSCESS 5621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DIVERTICULITIS DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 30 September 68, to 20 February 1969, that (I) (we) last saw the deceased alive on 20 February 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) R. S. STONE LCDR MC USNR					22e. ADDRESS		21 February 1969			
NAVAL HOSPITAL, ANNAPOLIS, MARYLAND										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		2/25/69		Arlington National Cem.		Arlington Va.				
24. FUNERAL DIRECTOR Beverly E. Hopping Hopping Funeral Home - Annapolis, Md.					25a. RECEIVED BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
01895						CERTIFICATE OF DEATH						01887	
1. DECEASED-NAME (Type or print) <i>SARAH</i>				First <i>SARAH</i> Middle <i>MILLER</i> Last <i>MILLER</i>				2a. DATE OF DEATH Month <i>February</i> Day <i>6</i> Year <i>69</i>				2b. HOUR <i>9:30 P.M.</i>	
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>March 7, 1883</i>				6. AGE (In years lost birth YRS. <i>85</i>)		IF UNDER 1 YEAR MONTHS <i>4</i> DAYS <i>14</i> HOURS <i>14</i> MIN.		IF UNDER 24 HRS. MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Ireland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i> Md.							
10. CITY OR TOWN OF DEATH <i>Pasadena, Md.</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>114 Arden Way</i>				12a. USUAL OCCUPATION (Kind of work done during preceding life (not retired.) <i>housewife</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>home maker</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> COUNTY <i>Baltimore</i> CITY <i>City</i>				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <i>1732 Carowell Street</i>					
14. FATHER'S NAME First <i>John</i> Middle <i>Gillen</i> Last <i>Gillen</i>				15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>McHale</i> Last <i>McHale</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <i>217-09-5608</i>		17. INFORMANT <i>Mr. Patrick Gillen</i> Address <i>114 Arden Way Pasadena, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i>												<i>6 weeks</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary arteriosclerotic heart disease</i>												<i>1 year</i>	
(c) <i>Cardiac decompensation</i>												<i>1 year</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>none</i>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>1</i> Day <i>3</i> Year <i>69</i> P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. <i>1/3</i> City or Town <i>69</i> County <i>2/6</i> State <i>69</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>1/3</i> , 19 <i>69</i> , to <i>2/6</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2/4</i> , 19 <i>69</i> , and that in (my) (aur) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>R.M. McLaughlin</i>				DEGREE <i>M.D.</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <i>2/6/69</i>					
22d. PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin, M.D.</i>				22e. ADDRESS <i>3708 Mountain Rd. Pasadena, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>				23b. DATE <i>2/10/69</i>				23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i>				23d. LOCATION (City or Town) <i>Baltimore, Md.</i> (County) <i>2/1</i> (State) <i>2</i>	
24. FUNERAL DIRECTOR <i>Charles L. Stevens Funeral Home, Inc.</i>				ADDRESS <i>1501 East Fort Avenue</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>FEB 10 1969</i>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 7/69

01896										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01888																																							
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR																													
Charles										moore										Month 2 Day 12 Year 69										M																													
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
M										W										8/19/06										62 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																			
PA. PHILA.										U.S.																				A.A. Co																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Crownsville St. Hosp.										Crownsville Hosp., Crownsville Md.										None																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
Md.										A.A. Co.										Glen Burnie										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										1216 Aster, DR.																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										Address																																							
First Middle Last										First Middle Last																																																	
unknown										unknown																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
										172-05-7115										Hospital records, Crownsville State Hospital																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a) Pneumonia																																																											
486X																																																											
DUE TO, OR AS A CONSEQUENCE OF																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)																																																	
										DUE TO, OR AS A CONSEQUENCE OF										(c)																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
Chronic alcoholism; with liver insufficiency; Chronic emphysema																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 2/10/69, to 2/12/69, that (I) (we) last saw the deceased alive on 2/12/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
Nureddin Erk, M.D.										2/13/69																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
Nureddin Erk, M.D.										Crownsville State Hospital, Maryland																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
BURIAL										2/15/69										Glen Haven Memorial Pk.										Glen Burnie, Maryland																													
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																							
Singleton Funeral Home, Glen Burnie, Md.										DATE FEB 17 1969																																																	

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Work

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 01897 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01889 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>											
1. DECEASED-NAME (Type or print) First Middle Last Charles Clarkson MORTON						2a. DATE OF DEATH Month Day Year February 27 1969			2b. HOUR P. 7:20 M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 28, 1903			6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Window Cleaner			12b. KIND OF BUSINESS OR INDUSTRY Empire Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 409 Maple Lane, N.W.				
14. FATHER'S NAME First Middle Last Charles Morton				15. MOTHER'S MAIDEN NAME First Middle Last Ida Calbalterson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		(If yes give war or dates of service) 1920 - ?		16b. SOCIAL SECURITY NO. 215/10/9080A		17. INFORMANT Mrs. Mary C. Morton			Address Same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emphysema 492X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Prof. Bronchogenic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of pancreas & metastases APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years 11											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 2-26, 1969 , to 2-27, 1969 , that (I) (we) last saw the deceased alive on 2-27, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Frank M. Shipley DEGREE F.M. SHIPLEY						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-28-69			
22d. PHYSICIAN'S NAME (Type) F.M. SHIPLEY						22e. ADDRESS 121 Cathedral St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/3/69		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem'l Park			23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.				
24. FUNERAL DIRECTOR Robert F. Ware Singleton Funeral, Glen Burnie, Md.						25a. RECEIVED BY REGISTRAR MAR 3 1969		25b. REGISTRAR'S SIGNATURE Robert F. Ware			

01889

STATE OF NEW YORK

01889



IN SENATE, January 1, 1909.

REPORT OF THE COMMISSIONER OF THE LAND OFFICE.

ALBANY: JAMES BRADY, STATE PRINTER, 1909.

RECEIVED JAN 1 1909

OFFICE OF THE COMMISSIONER OF THE LAND OFFICE

ALBANY, N. Y.

1909

REPORT OF THE COMMISSIONER OF THE LAND OFFICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Louse Tod		First Middle Last Motley		2a. DATE OF DEATH 2-13-69		2b. HOUR 3A M	
3. SEX F		4. RACE W		5. DATE OF BIRTH 8-6-87		6. AGE (In years last birthday) 81 YRS.	
7a. BIRTHPLACE (State or foreign country) VA		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) A.A. Gen Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) School		12b. KIND OF BUSINESS OR INDUSTRY Principal	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Severna Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. —		17. INFORMANT Address Hosp. Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. 4124 DUE TO, OR AS A CONSEQUENCE OF (b) a.c.v.d. DUE TO, OR AS A CONSEQUENCE OF (c) Anoxia							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1956, 19, to 1969, 19, that (I) (we) lost saw the deceased alive on 2-12-69 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Robert R. Hahn				DEGREE ATTENDING PHYS.		22c. DATE SIGNED 2-13-69	
22d. PHYSICIAN'S NAME (Type) Robert R HAHN				22e. ADDRESS P.O. Box 73 Severna Park			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2/15/69		23c. NAME OF CEMETERY OR CREMATORY Furnham Baptist Church		23d. LOCATION (City or Town) (County) (State) FARMINGTON, VA.	
24. FUNERAL DIRECTOR Robert S. Banamero		ADDRESS Severna Park, MD		25a. REC'D BY REGISTRAR DATE FEB 17 1969		25b. REGISTRAR'S SIGNATURE William C. Under	

MEDICAL CERTIFICATION

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UNITED STATES DEPARTMENT OF AGRICULTURE

02810

OFFICE OF THE SECRETARY

UNITED STATES DEPARTMENT OF AGRICULTURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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MEDICAL CERTIFICATION

2

2

VR A15ME (5)
10M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print) Calvin H Mullens						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 2 Day 24 Year 1969		2b. HOUR P M	
3. SEX M		4. RACE M		5. DATE OF BIRTH 5/10/1917		6. AGE (In years last birthday) 51 YRS.		2c. DATE PRONOUNCED DEAD Month 2 Day 24 Year 1969	
7a. BIRTHPLACE (State or foreign country) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Co		2d. HOUR P M	
10. CITY OR TOWN OF DEATH Tracy's Landing		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Freemont				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) STATE MD				13b. COUNTY Chesapeake		13c. CITY OR TOWN Tracy's Landing		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Unknown Middle Last 				15. MOTHER'S MAIDEN NAME First Mare Middle Mullens Last 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No				16b. SOCIAL SECURITY NO. 215-14-4136		17. INFORMANT ADDRESS John W. Mullens, Tracy's Landing, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124 Cardiac arrest due to atherosclerosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic alcoholism DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Short	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE E. Linhart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 2/24/69			
EXAMINER'S NAME (Type) E. Linhart St.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) 12000			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATOR		23d. LOCATION (City or Town) (County) (State) Bristol MD			
24. FUNERAL DIRECTOR William Reese #		ADDRESS Union Chapel		25a. REC'D BY REGISTRAR FEB 26 1969		25b. REGISTRAR'S SIGNATURE James Judge			

1881

RECEIVED FROM THE

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[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Frances (none) MURRAY						February 21 1969		3:00 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Negro		Feb. 13, 1886		83 YRS.		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis			Anne Arundel Gen. Hospital						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
STATE Maryland			Annapolis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt-2, Box 156		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Frank NMN Cromwell			Rachel NMN Colbert						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			218-28-8319		Caroline Jackson P.O. Box 323 Anna.M				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia; Congestive Heart Failure</u>								Years: 4 years	
4124 DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Pronounced Arteriosclerotic CV disease</u>								many years	
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Aug. 1968 to Present, 1969, that (I) (we) last saw the deceased alive on 2-20-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
PETER F. VERKOUW									2/21/69
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
PETER F. VERKOUW					1407 Forest Drive, Annapolis, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2-25-1969		Broadneck Church		A.A. Co Md			
24. FUNERAL DIRECTOR ADDRESS					25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
C.E. Hicks, 111 43-45 Northwest St					MAR 3 1969				

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Items 18&22a Film 411 Maryland State Department of Health
4-7-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01901

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01893

1. DECEASED NAME (Type or Print) GREGORY			First Middle Last E. MYRICK			2a. DATE KNOWN OF DEATH Month Day Year 2-26 1969			2b. HOUR M 4:45 A.M.		
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 8-29-65		6. AGE (in years last birthday) 3 YRS.		IF UNDER 1 YEAR MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN. 0 0	
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ANNE ARUNDEL		
10. CITY OR TOWN OF DEATH Ft. Geo. Meade			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) KIMBROUGH ARMY HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE			12b. KIND OF BUSINESS OR INDUSTRY NONE		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.			13b. COUNTY Prince George			13c. CITY OR TOWN Laurel			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER Rte. 1 Bx. 108			13f. CITY OR TOWN Whiskey Bottom Road			13g. STREET AND NUMBER Rte. 1 Bx. 108			13h. CITY OR TOWN Whiskey Bottom Road		
14. FATHER'S NAME First Middle Last RANDOLPH MYRICK			15. MOTHER'S MAIDEN NAME First Middle Last GRACE RYAN			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. NO		
17. INFORMANT GRACE MYRICK			18. ADDRESS BOX 80 R.F.D. #1 LAUREL, MD			19. DATE OF OPERATION 3-1-69			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
19a. DATE OF OPERATION 3-1-69			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Encephalomyocarditis			21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. DATE SIGNED February 27, 1969			22c. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22d. ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 3-1-69			23c. NAME OF CEMETERY OR CREMATORY MT ZION CEMETERY			23d. LOCATION (City or Town) (County) (State) LAUREL PR. GRGS. MD		
24. FUNERAL DIRECTOR ROBERT L. SNOWDEN			24b. ADDRESS ROCKVILLE, MD			25a. REC'D BY REGISTRAR MAK 4 1969			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

Wm. L. G. Smith

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MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) LAURENCE First Middle Last O'Brien		2a. DATE OF DEATH Month 2-9 Day 69 Year		2b. HOUR 2P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH 8/26/1890		6. AGE (In years lost birthday) 78 YRS.
7a. BIRTHPLACE (State or foreign country) Syracuse NY		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Allegany Md.		10. CITY OR TOWN OF DEATH Glenn Burns		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Avenue Ambulance Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD COUNTY Allegany		13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 814 Chester Balt 51
14. FATHER'S NAME First Middle Last Unknown		15. MOTHER'S MAIDEN NAME First Middle Last Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes WAR		16b. SOCIAL SECURITY NO. 08-44-0351		17. INFORMANT Max Ada Legg Address 814 Chester St
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Ventricular failure DUE TO, OR AS A CONSEQUENCE OF Cerebrovascular accident (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF years (c) Parkinson's syndrome				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours Months years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		
21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		
21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from 1/3, 1969 , to 2/9, 1969 , that (I) (we) last saw the deceased alive on 2/9, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE Max Ada Legg		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/10/69
22d. PHYSICIAN'S NAME (Type) MAX C FRANK		22e. ADDRESS 1215 N. High - Glenn Burns		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/12/69	23c. NAME OF CEMETERY OR CREMATORY Balto National Cem		23d. LOCATION (City or Town) (County) (State) Fredensht Rd Balto Md
24. FUNERAL DIRECTOR Fredensht J. Corp ADDRESS 7200 Hayford Road		25a. REC'D BY REGISTRAR FEB 11 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge

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01903										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01895									
CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR														
Katherine					F. Pawlak					Month 2 Day 7 Year 69					5:50a														
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
Female					White					11/24/90					78 YRS.														
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
unknown					US										Anne Arundel Md.														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY									
Crownsville					Crownsville State Hospital																								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					13b. CITY OR TOWN					13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER														
STATE Maryland					Baltimore										818 S. Decker Avenue														
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
First Middle Last					First Middle Last																								
Frank					Antoinette																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
unknown					216-09-7738					Hospital Records, Crownsville, Maryland																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Carcinoma of the breast</u>																													
174X DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																													
(b) <u>tear of the breast</u>																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
<u>Secondary anemia</u>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/9</u> , 19 <u>67</u> , to <u>2/7</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/7</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Alberto Gonzalez</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <u>2/7/69</u>														
22d. PHYSICIAN'S NAME (Type) <u>Alberto Gonzalez, M.D.</u>										22e. ADDRESS <u>Crownsville State Hospital, Maryland</u>																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
<u>Burial</u>					<u>2/10/1969</u>					<u>SACRED HEART OF JESUS</u>					<u>BALTIMORE MD.</u>														
24. FUNERAL DIRECTOR <u>RAYMOND L. KACIOROWSKI</u>										ADDRESS <u>2525 FLEET</u>					25a. REC'D BY REGISTRAR <u>DATE FEB 10 1969</u>					25b. REGISTRAR'S SIGNATURE <u>William J. ...</u>									

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100

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01905

CERTIFICATE OF DEATH

01897

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
Luther			C.	Porter Jr.	2 10 69			11:30 AM	
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Male	White		2/23/34			34 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Tennessee		US				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Crownsville			Crownsville State Hospital						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER		
Maryland			Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		277 Dallas Court		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Luther				Porter	Ruby				Brown
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			unknown		Hospital Records, Crownsville, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary occlusion, Coronary thrombosis DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from 12/31, 1968, to 2/10, 1969, that (I) (we) last saw the deceased alive on 2/10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Alberto Gonzalez</i>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/10/69		
22d. PHYSICIAN'S NAME (Type) Alberto Gonzalez, M.D.					22e. ADDRESS Crownsville State Hospital, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2-13-1969		Prospect Hill Cemetery		Towson, Maryland			
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson 1050 York Rd, 21204					25a. REC'D BY REGISTRAR DATE FEB 13 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

† 0356

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) John First Middle Last Posko					2a. DATE OF DEATH 2 Month 28 Day 69 year			2b. HOUR 5:30 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 5-30-02			6. AGE (In years lost birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.				
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY A.A. Co.		13c. CITY OR TOWN Crownsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Old Herold Harbor Rd. Rt. 2 box 360-A		
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>AJHD</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Right Pulmonary effusion - (Pleural)</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1967</u> , 19____, to <u>2/28/69</u> , 19____, that (I) (we) lost saw the deceased alive on <u>2/28/69</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>J. B. Ramirez</u>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) <u>J. B. RAMIREZ</u>			22e. ADDRESS <u>325 Hospital Dr Glen Burnie Md 21061</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 3-4-1969		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART OF MARY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND				
24. FUNERAL DIRECTOR WALTER DABROWSKI			ADDRESS 1005 DUNDALK AVENUE			25a. REC'D BY REGISTRAR DATE MAR 4 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

83850

U.S. DEPARTMENT OF AGRICULTURE

01000



10/10/10



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) John Murry Preston			2a. DATE OF DEATH Month FEB Day 15 Year 69			2b. HOUR 2155 P	
3. SEX Male		4. RACE Caucasion		5. DATE OF BIRTH 21 JULY 1901		6. AGE (In years last birthday) 67 YRS.	
7a. BIRTHPLACE (State or foreign country) Melrose Minnesota		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH AnnArundal Md.	
10. CITY OR TOWN OF DEATH Ft Geo G. Meade, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US Kimbrough Army Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Steam Engineer		12b. KIND OF BUSINESS OR INDUSTRY State Gov't	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Annarundal		13c. CITY OR TOWN Fort Meade		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1631 Walter Drive		14. FATHER'S NAME First Owen Andrew Middle Preston		15. MOTHER'S MAIDEN NAME First Elinor Middle (La'Forige) Last Preston			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 517-09-6324		17. INFORMANT Address (son) Terry Preston 1631 Walter Dr. FGGM, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular disease							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 6 days 30 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)							
19a. DATE OF OPERATION 14 FEB 69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Tracheotomy-Aspiration		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 15 FEB, 1969 , to 15 FEB , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 15 FEB 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Alan Lubin</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 16 FEB 1969	
22d. PHYSICIAN'S NAME (Type) ALAN LUBIN, CPT, MC		22e. ADDRESS 1812 Metzcott Rd., Hyattsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 21, 1969		23c. NAME OF CEMETERY OR CREMATORY Bethany Lutheran Cem.		23d. LOCATION (City or Town) (County) (State) Cushing, Minnesota	
24. FUNERAL DIRECTOR Howard Co. Funeral Home of Harry H. Witzke		24b. ADDRESS 4112 Columbia Pike Ellicott City, Md.		25a. REC'D BY REGISTRAR FEB 18 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01382

UNITED STATES

01382

John Henry ...

21 JUL 1941

United States ...

21 JUL 1941

21 JUL 1941

21 JUL 1941

21 JUL 1941

21 JUL 1941

21 JUL 1941

21 JUL 1941

21 JUL 1941

21 JUL 1941

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21 JUL 1941

21 JUL 1941

21 JUL 1941

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6 Film 409

2/20/69 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01900

1. DECEASED NAME (Type or Print) <i>Leon</i>		Middle		Last <i>Randall</i>		20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <i>2</i> Day <i>14</i> Year <i>1969</i>		2b. HOUR <i>9</i> AM	
3. SEX <i>M</i>	4. RACE <i>C</i>	5. DATE OF BIRTH <i>12-10-15</i>	6. AGE (In years last birthday) <i>54</i> RS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>2</i> Day <i>14</i> Year <i>1969</i>		2d. HOUR <i>9</i> AM	
7a. BIRTHPLACE (State or foreign country) <i>LOUISIANA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel County</i> Md.			
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Dist-North Arundel Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>NSA GOVT FT. MEAD</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>N. Arundel</i>		13c. CITY OR TOWN <i>Severna Park</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Rt 3 Box 26</i>	
14. FATHER'S NAME First <i>Phillip</i> Middle <i>Randall</i> Last				15. MOTHER'S MAIDEN NAME First <i>Julia</i> Middle <i>Chaney</i> Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>		16b. SOCIAL SECURITY NO. <i>4-30-42-65</i>		17. INFORMANT <i>Clementine Randall</i>		ADDRESS <i>2407 Lee St. Columbia, South Ca</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Disease</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>E. Linhardt</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>2-14-69</i>			
EXAMINER'S NAME (Type) <i>E. Linhardt</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, or county) <i>A.A. Co.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2-19-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Nat'l Cem</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR <i>MORTON & DYETT FUNERAL HOME, Balto. Md.</i>				ADDRESS		25a. REC'D BY REGISTRAR <i>FEB 17 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>	

00010

STUDY IN THE HISTORY OF THE UNITED STATES

1910

1. The first part of the study is a general survey of the history of the United States from the discovery of the continent to the present time. It is divided into three main periods: the colonial period, the revolutionary period, and the national period. The colonial period is characterized by the struggle for independence from Great Britain. The revolutionary period is marked by the adoption of the Declaration of Independence and the Constitution. The national period is the period of the growth and development of the United States as a nation.

2. The second part of the study is a detailed account of the events of the American Revolution. It begins with the outbreak of the war in 1775 and ends with the signing of the Treaty of Paris in 1783. It covers the military campaigns, the political struggles, and the social changes of the period. The study also includes a discussion of the role of the women of the Revolution and the impact of the war on the lives of the ordinary people.

3. The third part of the study is a critical analysis of the American Revolution. It examines the causes of the war, the course of the fighting, and the results of the Revolution. It also discusses the legacy of the Revolution and its influence on the development of the United States. The study concludes with a summary of the main findings and a list of references.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01909		01901	
1. DECEASED-NAME (Type or print) Mary E. RICE		2a. DATE OF DEATH February Month 4 , Day 1969 Year	
3. SEX Female		4. RACE Cauc.	
5. DATE OF BIRTH July 31, 1909		6. AGE (In years and birthday) 59 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.	
10. CITY OR TOWN OF DEATH Mayo		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NA	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland 13b. COUNTY Anne Arundel		13c. CITY OR TOWN Mayo	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER BEVERLY BEACH ROAD	
14. FATHER'S NAME First William Middle H. Last LEE		15. MOTHER'S MAIDEN NAME First REBECCA Middle E. Last BULLEN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown		16b. SOCIAL SECURITY NO.	
17. INFORMANT CHESTER A. RICE # 13		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition 1529 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic carcinoid syndrome DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 3 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) None			
19a. DATE OF OPERATION 1966		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoid, small intestine	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from June 22, 1967 , to Feb 4, 1969 , that (I) (we) last saw the deceased alive on January 10, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE Charles W. Kinzer		22c. DATE SIGNED February 4, 1969	
22d. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.		22e. ADDRESS 16 Murray Avenue, Annapolis, Md. 21401	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-2-69	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION (City or Town) (County) (State) Annapolis A.H. Md.	
24. FUNERAL DIRECTOR John M. Taylor & Sons Annapolis, Md.		25a. REC'D BY REGISTRAR FEB 7 1969	
25b. REGISTRAR'S SIGNATURE [Signature]			

1981

RECEIVED

1981

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]

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VR A15
45M - 1

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
01910					01902					
1. DECEASED-NAME (Type or print) First Middle Last					2a. DATE OF DEATH			2b. HOUR P		
Sigurd W ROBERTSON					2 Month 2 Day '69 Year			8:30 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		White		September 26, 1893.		15 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Oslo, Norway.		U.S.A.				Anne Arundel County Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			Anne Arundel General			RADIO REPAIR		ELECTRIC		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel		Annapolis		YES <input type="checkbox"/> NO <input type="checkbox"/>		736 Rosedale Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
UNK			UNK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
Yes, no, or unknown					SARA L. ROBERTSON # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124 CVA								1 week.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD Chronic brain syndrome								2 years.		
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Pneumonia - Bulbar paralysis - Aspiration										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1966, 19, to present 19, that (I) (we) last saw the deceased alive on 2-2-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)								2-3-69		
PETER F. VERKOWN										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		2-5-69		CEDAR BLVD		ANAPOLIS MD.				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
John M. Lytle				Annapolis, Md.		FEB 5 1969		[Signature]		

012010

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RECEIVED BY DEPT. OF HEALTH

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and travel costs

Referral fee

Investigation

and travel costs

Referral fee

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Referral fee

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
45M -

<div>01911</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>01903</div>															
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH Month Day Year				2b. HOUR			
Margaret				NMN ROSENAUER				February 13 1969				7:30P M			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		Cauc.		May 24, 1872 1880 189 88				YRS.		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH		Md.	
Hungary				USA				Anne Arundel							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis				Anne Arundel General				house wife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland				Anne Arundel				Annapolis		YES		Rt. 1, Box 582			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last											
Satarius				Hahn											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates all service)				16b. SOCIAL SECURITY NO.				17. INFORMANT Address							
no								Agnes K. Rosenauer - same as #13 above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Pneumonia, bilateral, pneumococcal												3 days			
4339 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b) Dysphagia and inanition												2 months			
DUE TO, OR AS A CONSEQUENCE OF															
(c) Arteriosclerotic cerebral thrombosis												2 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
Acute and chronic pyelonephritis with renal failure and azotemia															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
None				NA											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from January 28, 1969, to February 13, 1969, that (I) (we) last saw the deceased alive on February 13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.															
22b. SIGNATURE Charles W. Kinzer								DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED February 14, 1969					
22d. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.								22e. ADDRESS 16 Murray Ave., Annapolis, Md. 21401							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				2/17/69		St. Mary's Cemetery				Annapolis A.A. Md.					
24. FUNERAL DIRECTOR: Beverley E. Hopping ADDRESS HOPPING FUNERAL HOME - Annapolis, Md.															
25a. REC'D BY REGISTRAR FEB 19 1969								25b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

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01912										01904																			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print) LILLIAN					First MARY					Middle RUSSELL					Last					2a. DATE OF DEATH 2 Month 23 Day 1969					2b. HOUR 8-A M				
3. SEX Female					4. RACE White					5. DATE OF BIRTH 9/9/1885					6. AGE (In years last birthday) 83 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN				
7a. BIRTHPLACE (State or foreign country) Maryland					7b. CITIZEN OF WHAT COUNTRY? U. S. A.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Anne Arundel Md.														
10. CITY OR TOWN OF DEATH Linthicum Heights					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 215 N. Hammonds Ferry Rd.					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife					12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland 13b. COUNTY Anne Arundel					13c. CITY OR TOWN Linthicum					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER 215 N. Hammonds Ferry Rd.														
14. FATHER'S NAME First Philip ? Middle ? Last Weber					15. MOTHER'S MAIDEN NAME First Catherine ? Middle ? Last Connolly																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No. (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. 213-50-1066					17. INFORMANT Clarence R. Russell					Address 506 S. Hammonds Ferry Rd.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatous 1541 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, rectum DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 12-27, 1968 , to 2-23, 1969 , that (I) (we) lost the deceased alive on 2-11, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE D. C. Sorongon										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 2-24-69														
22d. PHYSICIAN'S NAME (Type) D. C. SORONGON										22e. ADDRESS 3915 HOLLINS FERRY RD. BALTO, Md. 21227																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 2/26/1969					23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery Baltimore, Md.					23d. LOCATION (City or Town) (County) (State)														
24. FUNERAL DIRECTOR Raymond C. Fink										ADDRESS Glen Burnie, Md.					25a. REC'D BY REGISTRAR FEB 25 1969					25b. REGISTRAR'S SIGNATURE [Signature]									

1912

RECORD OF DEATH

1912

LILLIAN MARY ROSSALL

White 2/3/1902

Maryland U. S. A. Anne Arundel

Interment Heights 215 W. Hammond Ave. Baltimore

Maryland Anne Arundel Baltimore x 215 W. Hammond Ave. Baltimore

Philip Weber Catherine Connolly

213-50-1000 Clarence E. Rossall 500 S. Hammond

2/20/1900 New Cathedral Cemetery Baltimore, Md.

and C. Rick also buried, Md.

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VR 115
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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
01913					01905					
1. DECEASED-NAME (Type or print) First Middle Last					2a. DATE OF DEATH			2b. HOUR		
MARGARET (PEGGY) SMITH SANDROCK					Feb Month 25 Day Year 1969			355A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		White		Feb 4, 1909		60 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
BALTIMORE		U.S.A.				ANNE ARUNDEL Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
RURAL ANNAPOLIS			RT 2 BOX 5 ANNAPOLIS			TYPIST		U.S. Govt		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD			ANNE ARUNDEL		ANNAPOLIS		YES		ST MARGARETS RD RT 2 BOX 5 ANNAPOLIS MD	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
EDGAR SMITH			LOUISE B. HAMMER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
NO					23 ANNAPOLIS BLVD EDGAR SMITH SEVERNA PARK MD 21146					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma</u> <u>1979</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of porta hepatis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>7-22</u> , 19 <u>66</u> , to <u>Feb 25</u> , 19 <u>69</u> , that (I) (we) lost the deceased alive on <u>Feb 24</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Ray M. Smith MD</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>Feb. 25/1969</u>				
22d. PHYSICIAN'S NAME (Type) <u>RAY M. SMITH</u>						22e. ADDRESS <u>SEVERNA PARK, MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<u>CREMATION</u>		<u>FEB 25, 1969</u>		<u>FORT LINCOLN CREM.</u>		<u>PRINCE GEO. CO. MD.</u>				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
<u>JOHN M. TAYLOR, 505 ANNAPOLIS MD</u>				<u>FEB 27 1969</u>		<u>Charles J. [Signature]</u>				

81013

REPUBLIC OF DENMARK

1962

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) CHRISTOPHER A. SCHMIDT			2a. DATE OF DEATH Month 2 Day 17 Year 69			2b. HOUR 11:45 M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 5/28/1890		6. AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		
7a. BIRTHPLACE (State or foreign country) Minnesota		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.				
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NORTH ARUNDUEL CONV. CTR			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY Sheet Metal		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3206 OVERLAND AVE	
14. FATHER'S NAME First Middle Last Gustave Schmidt			15. MOTHER'S MAIDEN NAME First Middle Last Dorothis Zinnie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 388-07-4222		17. INFORMANT Address Mildred S. Glomp (Daughter) Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Ventricle failure 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Coronary Insufficiency									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours hours years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) General arteriosclerosis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from July 14, 1967 to 2/11, 1969 , that (I) (we) last saw the deceased alive on 2/11, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Max C Frank				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/11/69				
22d. PHYSICIAN'S NAME (Type) MAX C FRANK				22e. ADDRESS 427 SE Arthur Hwy Glen Burnie Md 21061						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE Feb. 14, 1969		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.				
24. FUNERAL DIRECTOR Eugenia K. Seitz 5209 York Rd. Seitz Funeral Home Balto. Md. 21212				25a. REC'D BY REGISTRAR DATE FEB 13 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

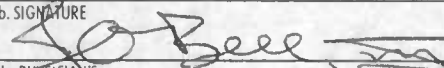

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01915

CERTIFICATE OF DEATH

01907

1. DECEASED-NAME (Type or print) JOHN WESLEY SCHUMAN, SR.			2a. DATE OF DEATH Month February Day 28 Year 1969			2b. HOUR 1720 M				
3. SEX MALE		4. RACE CAUCASION		5. DATE OF BIRTH 16 MAY 1920		6. AGE (In years last birthday) 48 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL Md.				
10. CITY OR TOWN OF DEATH ANNAPOLIS			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FED. EMPLOYEE			12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 213 LOCKWOOD COURT, ANNA.	
14. FATHER'S NAME First Middle Last JOHN F. SCHUMAN			15. MOTHER'S MAIDEN NAME First Middle Last ELLA GOTCHALK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) YES 41-64			16b. SOCIAL SECURITY NO.		17. INFORMANT Address MRS. SUE H. SCHUMAN 213 LOCKWOOD COURT, ANN					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 4121 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) GOLDBLATT KIDNEY									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE  DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED 03 MARCH 1969					
22d. PHYSICIAN'S NAME (Type) J. O. BELL 111 LT MC USNR					22e. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MARYLAND					
23a. BURIAL, CREMATION, or other disposal BURIAL		23b. DATE 3/5/1969		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL			23d. LOCATION (City or Town) (County) (State) ARLINGTON VA			
24. FUNERAL DIRECTOR ADDRESS JOHN M TAYLOR SONS ANNAPOLIS MD					25a. REC'D BY REGISTRAR DATE MAR 7 1969		25b. REGISTRAR'S SIGNATURE 			

70210

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
01916					01908				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR		
Thelma M. Simms					February 26 1969		10:10A		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		June 13, 1908		60 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie			North Arundel Hospital			Payroll Clerk		Plastic	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland				Prince George		Laurel		YES	
14. FATHER'S NAME First Middle Lost				15. MOTHER'S MAIDEN NAME First Middle Lost		13e. STREET AND NUMBER			
David Knight				Minnie King		800 Fairlawn Avenue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
no						Ernest Simms, same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>2 weeks</i>									
1538 DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2-20-69		Intestinal Obstruction		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from April 1967, to 2-26-69, that (I) (we) last saw the deceased alive on 2-26-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Charles A. Mac Donald</i>				22c. DATE SIGNED		22d. ADDRESS			
						325 Hospital Drive Glen Burnie, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1 March 69		Holy Trinity Church Cem.		Elkridge, Howard Co., Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Kirkley Funeral Home, Glen Burnie, Md.				FEB 28 1969		<i>J. Charles Judge</i>			

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11-10-10

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <u>Slaughter, George H.</u>					2a. DATE OF DEATH Feb. Month <u>24</u> Day <u>69</u> Year			2b. HOUR <u>6:50</u> P. M.	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>6-21-04</u>		6. AGE (In years last birthday) <u>64</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Anne Arundel, Maryland</u> Md.			
10. CITY OR TOWN OF DEATH <u>Glen Burnie</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>North Arundel Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Retired</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Ind Drydock</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Anne Arundel</u>		13c. CITY OR TOWN <u>Glen Burnie</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>Rt. 14 Box 19 Pasadena, Md.</u>	
14. FATHER'S NAME First Middle Last <u>Adolph Slaughter</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>Nora Foster</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16b. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs Lottie Slaughter Glowe</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock, C.A.</u> <u>2509</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>diabetes mellitus from overcolony</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>prolonged disturbance</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>1 mo</u> <u>1 mo</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION <u>2-17-69</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>diverticulitis post.</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <u>69</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 11, 1969</u> , to <u>Feb 24, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb 24, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>S. Alvarez</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>2-24-69</u>					
22d. PHYSICIAN'S NAME (Type) <u>S. ALVAREZ</u>		22e. ADDRESS <u>N.A. Hosp.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/28/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cmt.</u>		23d. LOCATION (City or Town) (County) (State) <u>Bethesda Md. 21225</u>			
24. FUNERAL DIRECTOR <u>Robert S. Baranov</u>		ADDRESS <u>Severna Park</u>		25. FILED BY REGISTRAR <u>FEB 27 1969</u>		25c. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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01918

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01910

1. DECEASED-NAME (Type or print) Ellsworth Carroll SMITH, Sr.			2a. DATE OF DEATH Month February Day 20 Year 1969			2b. HOUR 11:10 A.M.					
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 23, 1903		6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel			Md.		
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life. Do not include retired.) PLASTERER			12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVMT.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. CITY OR TOWN Anne Arundel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Edgewater				
14. FATHER'S NAME First — Middle — Last —			15. MOTHER'S MAIDEN NAME First — Middle — Last —								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. —		17. INFORMANT NORA V. SMITH Address #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 441.2 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic occlusion of aorta (abdominal) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 1 week 2 weeks(?)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Heart failure. Laennec's cirrhosis, Aortic stenosis with relative mitral insufficiency,											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (the hospital) attended the deceased from 2/16, 1969 , to 2/20, 1969 , that (I) (we) last saw the deceased alive on 2/20, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles W. Kinzer					DEGREE — ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED February 21, 1969				
22d. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.					22e. ADDRESS 16 Murray Ave., Annapolis, Maryland 21401						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2/24/1969		23c. NAME OF CEMETERY OR CREMATORY MAYO MEM. CEM.			23d. LOCATION (City or Town) (County) (State) MAYO AACO, MD.				
24. FUNERAL DIRECTOR JOHN M. TAYLOR & SONS ANNAPOLIS MD					ADDRESS —		25a. RECEIVED BY REGISTRAR FEB 24 1969		25b. REGISTRAR'S SIGNATURE —		

1918

THE STATE OF TEXAS

1918

County of _____ State of _____

Know all men by these presents, _____ of the County of _____ State of _____ do hereby certify that _____ of the County of _____ State of _____ is the owner of _____ and that the same is subject to a lien in favor of _____ for the sum of _____ Dollars (\$ _____) and interest thereon at the rate of _____ per cent per annum, and that the same is due and payable on or before the _____ day of _____ 19____.

Witness my hand and seal of office this _____ day of _____ 19____.

County Clerk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01919										01911														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR									
Frank					V. Smith					Month 2/10 Day 11:45 PM					Year 45 69									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.									
Male			White			8/2/62			56 YRS.			MONTHS DAYS HOURS MIN.												
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH									
Maryland					US										Anne Arundel Md.									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY									
Crownsville					Crownsville State Hospital					CIVIL SERVICE					RET.									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER				
Maryland					Anne Arundel					Annapolis					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					215 Taylor Avenue				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																			
First Middle Last					First Middle Last																			
William Frank					Smith					Bertha					Kucinski									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address									
yes					unknown					Hospital Records, Crownsville State Hospital														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) <u>Stroke</u>																								
4109 DUE TO, OR AS A CONSEQUENCE OF																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																								
(b) <u>Myocardium infarction</u>																								
DUE TO, OR AS A CONSEQUENCE OF																								
(c) <u>H.S. V.D.</u>																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
<u>Acute alcoholic intoxication</u>																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
					HOUR A.M. Month Day Year P.M. 19																			
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION					Street or R.F.D. No. City or Town County State									
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>																								
22a. I certify that (I) (this hospital) attended the deceased from <u>2/7</u> , 19 <u>69</u> , to <u>2/10</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/10</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE										DEGREE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED				
<u>Ally Arzalez</u>																				2/11/69				
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS														
Alberto Gonzalez, M.D.										Crownsville State Hospital, Maryland														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
BURIAL					2-13-69					ST. STANISLAUS					Baltimore MD.									
24. FUNERAL DIRECTOR										ADDRESS					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
<u>John M. Long</u>										<u>Princeton, Md.</u>					FEB 14 1969					<u>James J. Judge</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01920

01912

1. DECEASED-NAME (Type or print) Kay		First L.		Middle Smith		Last Smith		2a. DATE OF DEATH Month February Day 10 Year 1969		2b. HOUR 9:45a	
3. SEX Female		4. RACE White		5. DATE OF BIRTH October 18, 1924		6. AGE (In years last birthday) 44 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 905 Rosedale Avenue			
14. FATHER'S NAME First John Middle Wasilko Last Wasilko		15. MOTHER'S MAIDEN NAME First Sadie Middle XXXXXXXXXXXX Last Adamchak									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 193-18-1126		17. INFORMANT Address Glen Burnie Md. Robert F. Smith, Jr., 905 Rosedale Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 1541 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of rectum DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 12-7, 1968 to 2-10, 1969 , that (I) (we) lost saw the deceased alive on 2-10, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ernest Tolentino		22c. DATE SIGNED 2-10-69		22d. PHYSICIAN'S NAME (Type) Ernest Tolentino							
22e. ADDRESS North Arundel General Hospital											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-13-1969		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park		23d. LOCATION (City or Town) (County) (State) Ritchie Hwy A. A. Md.					
24. FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR DATE FEB 13 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge							

11212

11250

1. The first of the three main parts of the report is a description of the work done during the year. This is followed by a summary of the results obtained, and finally a discussion of the work done during the year.

2. The second part of the report is a description of the work done during the year. This is followed by a summary of the results obtained, and finally a discussion of the work done during the year.

3. The third part of the report is a description of the work done during the year. This is followed by a summary of the results obtained, and finally a discussion of the work done during the year.

1. The first of the three main parts of the report is a description of the work done during the year. This is followed by a summary of the results obtained, and finally a discussion of the work done during the year.

2. The second part of the report is a description of the work done during the year. This is followed by a summary of the results obtained, and finally a discussion of the work done during the year.

3. The third part of the report is a description of the work done during the year. This is followed by a summary of the results obtained, and finally a discussion of the work done during the year.

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VR A15
30M REV. 1-60

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
Items 5&7 Film 409 2/26/69 kk															
CERTIFICATE OF DEATH															
01913															
1. DECEASED NAME (Type or print)			First JAMES		Middle W.		Last SPENCER		2a. DATE OF DEATH 2 Month 9 Day Year 69		2b. HOUR 11:12 P.M.				
3. SEX Male			4. RACE Negro			5. DATE OF BIRTH 12-20-87 1880			6. AGE (In years last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH A.A.						
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY A.A.			13c. CITY OR TOWN Glen Burnie			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 282 Solley Rd., Rt. 1				
14. FATHER'S NAME First James			Middle Spencer			Last Spencer			15. MOTHER'S MAIDEN NAME First Laura			Middle -			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT Chart			Address North Arundel						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 Cardiac decompensation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 years 7 years															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) none															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from Sept. 6 , 19 49 , to Feb. 9 , 19 69 , that (I) (we) last saw the deceased alive on Jan. 20 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE R.M. McLaughlin										DEGREE MED. DIRECTOR		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/10/69	
22d. PHYSICIAN'S NAME (Type) Dr. Randal McLaughlin										22e. ADDRESS 3708 Mountain Road, Pasadena, Md. 21122					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/13/69			23c. NAME OF CEMETERY OR CREMATORY Halls			23d. LOCATION (City or Town) (County) (State) Baltimore						
24. FUNERAL DIRECTOR Ed Brown						ADDRESS 100 W. Mount Vernon			25a. REC'D BY REGISTRAR 4		25b. REGISTRAR'S SIGNATURE Charles Judge				
DATE FEB 13 1969															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Nettie L. Styles						2 Month 11 Day 69 Year			M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		Caucasian		7/1/83			85 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsy.		U.S.A.				Pasadena / Anne Arundel Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Pasadena, Md.			North Arundel Center			Housework (ret.)		Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Anne Arundel		Riviera Beach		YES		#215 Wanda Road
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Edward J. Cook			Catherine Campbell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			unknown		Mrs. Grace A. Cook (sister-in-law) #13 Same As				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic C-V Disease</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/9</u> , 19 <u>65</u> , to <u>2/11</u> , 19 <u>69</u> , that (I) (was) last saw the deceased alive on <u>Dec</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (did not) (did not) view the body after death.									
22b. SIGNATURE <u>C. Earl Hill</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>2/11/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Dr. C. Earl Hill, M. D.</u>						22e. ADDRESS <u>395 Ft. Smallwood Rd., Pasadena, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Cremation		Feb. 19, 1969		Loudon Park Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR <u>R. Singleton</u>		ADDRESS <u>Glen Burnie, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 17 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
01923 <i>Hulda</i>						01916					
1. DECEASED-NAME (Type or print) <i>Hulda</i>			First <i>R.</i>			Middle <i>Taylor</i>			Last		
2a. DATE OF DEATH			Month <i>2</i>			Day <i>12</i>			Year <i>1969</i>		
2b. HOUR <i>10:45</i>			PM								
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>11-27-1866</i>			6. AGE (In years last birthday) <i>102</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>Germany</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Anne Arundel</i> Md.		
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>N. Arundel Convalescent Center</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Baltimore</i>			13c. CITY OR TOWN <i>Baltimore</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER <i>7916 East End Dr. Orchard Beach</i>			14. FATHER'S NAME First <i>Unknown</i>			Middle			Last		
15. MOTHER'S MAIDEN NAME First <i>Unknown</i>			Middle			Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>219-54-4268-J1</i>			17. INFORMANT <i>Maxwell H. Horz</i> Address <i>3679 St. Margaret St.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Left ventricular failure</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Myocardial Infarction</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized arteriosclerosis</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR <i>3/9</i> A.M. Month <i>6</i> Day <i>2</i> Year <i>1969</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. <i>425 SE Ritchie Hwy</i> City or Town <i>Coleen Burne</i> County <i>21061</i> State					
22a. I certify that (I) (this hospital) attended the deceased from <i>2/12/69</i> to <i>2/12/69</i> , that (I) (we) last saw the deceased alive on <i>2/12/69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Max C. Frank</i>			DEGREE <i>MD</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>2/13/69</i>		
22d. PHYSICIAN'S NAME (Type) <i>MAX C. FRANK MD</i>			22e. ADDRESS <i>425 SE Ritchie Hwy</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>2-15-69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>			23d. LOCATION (City or Town) <i>Anne Arundel Co., Md.</i> (County) (State)		
24. FUNERAL DIRECTOR <i>George J. Gonce</i>			ADDRESS <i>4001 Ritchie Hwy. Balto., Md.</i>			25a. REC'D BY REGISTRAR <i>FEB 18 1969</i>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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Handwritten notes and signatures in the top section of the document.

Handwritten notes and signatures in the middle section of the document.

Handwritten notes and signatures in the bottom section of the document.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01924

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01917

1. DECEASED-NAME (Type or print) <i>Noah W. Taylor</i>			2a. DATE OF DEATH Month <i>2</i> Day <i>19</i> Year <i>1969</i>			2b. HOUR M				
3. SEX <i>Male</i>		4. RACE <i>Col.</i>		5. DATE OF BIRTH <i>3-7-1896</i>		6. AGE (In years last birthday) <i>72</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>A. A.</i> Md.				
10. CITY OR TOWN OF DEATH <i>Annapolis</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>413 Oaklawn Rd.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution—Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>A. A.</i>		13c. CITY OR TOWN <i>Annapolis</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>413 Oaklawn Rd.</i>	
14. FATHER'S NAME First Middle Last <i>Unknown</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Lizzie Taylor</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>yes</i> (If yes, give war in which of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Josephine Taylor Annapolis</i> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute cardiac arrest</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arterio-sclerotic cardiac vascular changes</i> DUE TO, OR AS A CONSEQUENCE OF <i>Diabetes</i> (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>2-25-69</i> , 19____, to <i>2-19-69</i> , 19____, that (I) (we) last saw the deceased alive on <i>2-17-69</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>W. T. O'Leary MD</i>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2-19-69</i>					
22d. PHYSICIAN'S NAME (Type) <i>W. T. O'Leary MD</i>			22e. ADDRESS <i>62 Gethsemane St</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>2-22-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Pine Lawn</i>		23d. LOCATION (City or Town) (County) (State) <i>Annapolis Md.</i>			
24. FUNERAL DIRECTOR <i>William Reese</i>			ADDRESS <i>Annapolis Md.</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 20 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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FEB 10 1964
U.S. AIR FORCE
HONOLULU, HAWAII

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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01925		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01918	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) DAISY		First Pauline Middle THOMPSON		2. DATE OF DEATH February 14 Day 69 Year		2b. HOUR 5:05 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 12-28-94		6. AGE (In years, months, days) 74 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Maryland Md.	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if first admission) STATE Maryland		13b. COUNTY FREDERICK		13c. CITY OR TOWN BRUNSWICK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME George		First George Middle T. Last Danner		15. MOTHER'S MAIDEN NAME Flora M. Middle Harrison		13e. STREET AND NUMBER 14 E.B. St. Brunswick, Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (known)		16b. SOCIAL SECURITY NO. 213-30-0091		17. INFORMANT August C.W. Gibbons		17b. ADDRESS Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4273 DUE TO, OR AS A CONSEQUENCE OF (b) ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) Right Bundle Branch complete block Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1-20-1969 , to 2-14-1969 , that (I) (we) last saw the deceased alive on 2-14-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Orlando E. Ramos				DEGREE MD. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 2-14-69	
22d. PHYSICIAN'S NAME (Type) Orlando E. Ramos				22e. ADDRESS Glen Burnie Md. Arundel Medical Group Ritchie			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/18/69		23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		23d. LOCATION (City or Town) (County) (State) Knoxville, Maryland Highly	
24. FUNERAL DIRECTOR Reese Funeral Home				24b. ADDRESS Brunswick, Md.		25a. RECEIVED BY REGISTRAR FEB 18 1969	
				25b. REGISTRAR'S SIGNATURE [Signature]			

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) ELIZABETH NMN TONGUE			2a. DATE OF DEATH Month 2 Day 8 Year 69			2b. HOUR 9A M			
3. SEX F		4. RACE NEGRO		5. DATE OF BIRTH 4-4-99		6. AGE (In years last birthday) 69		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Conventcent Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 446 Drew St	
14. FATHER'S NAME First Middle Last WILLIAM NMN Saunders			15. MOTHER'S MAIDEN NAME First Middle Last Margaret NMN Tydings			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. 217-463732			17. INFORMANT Margaret Green			Address 1919 VINCENT ST			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of @ lung DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days month	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Nov. 7, 1968 , to Feb. 8, 1969 , that (I) (we) lost the deceased alive on Feb. 8, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jack I. Stern, M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/8/69			
22d. PHYSICIAN'S NAME (Type) Jack I Stern, M.D.		22e. ADDRESS 425 Ritchie Hwy S.E. Glen Burnie Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-11-1969		23c. NAME OF CEMETERY OR CREMATORY PINELAWN Memorial PK		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS A.A. MD			
24. FUNERAL DIRECTOR Hicks Funeral Home		ADDRESS 43 N WEST ST		25a. REC'D BY REGISTRAR FFB 13 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

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01927		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01920		
1. DECEASED-NAME (Type or print) RHODA E. Trott						2a. DATE OF DEATH Month 2 Day 5 Year 69		2b. HOUR 8 M
3. SEX F	4. RACE W	5. DATE OF BIRTH 7-16-1892		6. AGE (In years lost birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNIE ARUNDEL Md.		
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 171 Acton Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOME		12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY H.A. Annapolis		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 171 Acton Rd.		14. FATHER'S NAME First Middle Last THOMAS Stinchcomb		15. MOTHER'S MAIDEN NAME First Middle Last GRACE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 219 16 0955		17. INFORMANT BERNARD WHITE		Address 7 RIVERVIEW AVE. ANNAPOLIS, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease 4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (1) (this hospital) attended the deceased from June , 19 68 , to Feb. , 19 69 , that (1) (we) last saw the deceased alive on 1/26 , 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.								
22b. SIGNATURE John M. Taylor		22c. DATE SIGNED 2/6/69		22d. PHYSICIAN'S NAME (Type) Freest Dr. Annapolis, MD.		22e. ADDRESS Freest Dr. Annapolis, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-7-1969		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION (City or Town) (County) (State) Annapolis H.A. MD.		
24. FUNERAL DIRECTOR John M. Taylor		24a. ADDRESS Chesapeake, Md.		25a. FILED BY REGISTRAR FEB 10 1969		25b. REGISTRAR'S SIGNATURE		

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
01928						01921					
1. DECEASED-NAME (Type or print) JACOB JAY VANDERGRIFF, JUNIOR						2a. DATE OF DEATH Month February Day 5 Year 1969			2b. HOUR 4:00 AM		
3. SEX MALE		4. RACE Caucasian		5. DATE OF BIRTH 25 April 1917			6. AGE (In years last birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS 5 DAYS 19		IF UNDER 24 HRS. HOURS 4 MIN. 00
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL Md.					
10. CITY OR TOWN OF DEATH ANNAPOLIS			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U. S. NAVY			12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 29 UPSHUR ROAD		
14. FATHER'S NAME First JACOB Middle JAY Last VANDERGRIFF				15. MOTHER'S MAIDEN NAME First MAJORIE Middle HOLMES Last HOLMES							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES (If yes give war or dates of service) 1939-1969				16b. SOCIAL SECURITY NO. 176 32 3500		17. INFORMANT SERVICE RECORD Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 441.0 IMMEDIATE CAUSE (a) AORTIC ANEURYSM, DISSECTING DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year 19 P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____					
22a. I certify that (I) (this hospital) attended the deceased from 2 February, 1969 , to 5 February 1969 , that (I) (we) lost the deceased on 5 February 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>A. C. J. Brickel</i>						DEGREE <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 5 February 1969			
22d. PHYSICIAN'S NAME (Type) A. C. J. BRICKEL LT MC USNR						22e. ADDRESS Naval Hospital, Annapolis, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/7/69		23c. NAME OF CEMETERY OR CREMATORY Naval Academy Cemetery		23d. LOCATION (City or Town) (County) (State) Annapolis, Maryland					
24. FUNERAL DIRECTOR Howard County Funeral Home of Harry H. Witzke, Ellicott City, Md.						25a. REC'D BY REGISTRAR FEB 7 1969 DATE		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01929

CERTIFICATE OF DEATH

01922

1. DECEASED-NAME (Type or print) Bertha Pindell VanHorne			2a. DATE OF DEATH Month February Day 17 Year 1969			2b. HOUR 2:05AM						
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH August 5, 1889		6. AGE (In years last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0		
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.						
10. CITY OR TOWN OF DEATH Millersville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Knollwood Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b. COUNTY AA		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 131 BEST GATE Rd			
14. FATHER'S NAME First HARRY Middle GREEN Last GREEN			15. MOTHER'S MAIDEN NAME First Alice Middle BUCKLEY Last BUCKLEY									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 219-54-3449T		17. INFORMANT Allen S. VanHorne			Address ANNAPOLIS, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - - - - - 4409 DUE TO, OR AS A CONSEQUENCE OF (b) Heart failure - - - - - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerosis - - - - -										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days many years many years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Atrial fibrillation, Obesity, Senility, Osteoarthritis, Gout, Migraine												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (the physician) attended the deceased from February 8, 1969 to Feb 17, 1969 , that (I) (we) last saw the deceased alive on Feb 16, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.												
22b. SIGNATURE Charles W. Kinzer						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Feb 17, 1969				
22d. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.						22e. ADDRESS 16 Murray Avenue, Annapolis, Md. 21401						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 2-19-69		23c. NAME OF CEMETERY OR CREMATORY Hillcrest			23d. LOCATION (City or Town) (County) (State) ANNAPOLIS AA Md				
24. FUNERAL DIRECTOR Hardesty Funeral Home						ADDRESS Annapolis, Md		25a. REC'D BY REGISTRAR DATE FEB 24 1969		25b. REGISTRAR'S SIGNATURE William J. ...		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01923

1. DECEASED-NAME (Type or print) SAMUEL LITHICUM VAUGHN			2a. DATE OF DEATH Month FEBRUARY Day 19 Year 1969			2b. HOUR 0805 M					
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 18 MAY 1906		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.		IF UNDER 24 HRS. HOURS 0 MIN.	
7a. BIRTHPLACE (State or foreign country) KENTUCKY			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ANNE ARUNDEL Md.		
10. CITY OR TOWN OF DEATH ANNAPOLIS			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U. S. NAVY			12b. KIND OF BUSINESS OR INDUSTRY Ret.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN SEVERNA PK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ROUTE 1 BOX 327		
14. FATHER'S NAME First Middle Last WILLIAM VAUGHN			15. MOTHER'S MAIDEN NAME First Middle Last UNK								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 1926 1946			17. INFORMANT WIFE MILDRED R. VAUGHN #13			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 425X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), (b) CARIDO MYOPATHY stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R. S. Stone						DEGREE ATTENDING <input type="checkbox"/> MED. <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYS. DIRECTOR PHYS.			22c. DATE SIGNED 2/21/69		
22d. PHYSICIAN'S NAME (Type) R. S. STONE LCDR. MC USNR						22e. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE FEB 24 1969			23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL			23d. LOCATION (City or Town) (County) (State) ARLINGTON VA.		
24. FUNERAL DIRECTOR JOHN M. TAYLOR SONS ANNAPOLIS MD.						25a. REC'D BY REGISTRAR DATE FEB 24 1969			25b. REGISTRAR'S SIGNATURE William J. Young		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
01931				01924					
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
Michael WLODZIEWSKI (or) Wachowski						2	10	69 11:45 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (If infant, last date of birth)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
Male		White		NOV 18 1905 unknown		63			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
BALTO MD unknown		US				Anne Arundel			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Crownsville		Crownsville State Hospital		SEA MAN					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		BALTO		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		1605 Alice Ann Avenue	
14. FATHER'S NAME		First Middle Last		15. MOTHER'S MAIDEN NAME		First Middle Last			
Joseph		Wachowski		Mary		MORAWSKA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no		220-54-9126		Hospital Records, Crownsville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardium infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>A-S-U-D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Epilepsy but definitely -</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>2/6</u> , 19 <u>69</u> , to <u>2/10</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/10</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Alberto Gonzalez</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <u>2-10-69</u>			
22d. PHYSICIAN'S NAME (Type) Alberto Gonzalez, M.D.						22e. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, or other disposal		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		FEB 12 1969		GARDENS OF FAITH CEM		TRUMPS MILL RD BALTO MD			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
THE DIPPEL BROS INC		1800 E LOYBARO ST		FEB 14 1969					

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[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "RECEIVED" and "OFFICE" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

01932

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01925

1. DECEASED-NAME (Type or print) George - Wallace (Walas)			2a. DATE OF DEATH Month February Day 12 Year 1969			2b. HOUR 12:30					
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 27, 1898		6. AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired			12b. KIND OF BUSINESS OR INDUSTRY U.S.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE M.D.			13b. COUNTY Millersville		13c. CITY OR TOWN A.A.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 73, Indian Landing Rd.		
14. FATHER'S NAME First Middle Last Adam Walas			15. MOTHER'S MAIDEN NAME First Middle Last Rosalie (unknown)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 215-01-1268		17. INFORMANT Address Mrs. Anna Z. Wallace-Millersville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction - 4109 DUE TO, OR AS A CONSEQUENCE OF (b) ASHD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHF - Pulmonary edema - Ventricular tachycardia -									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2/5/69 , 19__, to 2/12/69 , 19__, that (I) (we) last saw the deceased alive on 2/11/69 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. B. Ramirez						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/12/69			
22d. PHYSICIAN'S NAME (Type) J. B. RAMIREZ						22e. ADDRESS 325 Hospital Drive Suite 207 Glen Burnie Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/15/69		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery			23d. LOCATION (City or Town) (County) (State) Dundalk, Maryland			
24. FUNERAL DIRECTOR R. P. Ware						ADDRESS Singleton Funeral Home/Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE FEB 17 1969		25b. REGISTRAR'S SIGNATURE William J. Jones	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01933										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01927									
Item 1 Film 409 2/18/69 kk										CERTIFICATE OF DEATH																			
1. DECEASED NAME (Type or print) Minnie					First E. Middle Webster Last					2a. DATE OF DEATH Feb Month 1969 Day					2b. HOUR M														
3. SEX Female					4. RACE White					5. DATE OF BIRTH Feb 28, 1884					6. AGE (In years last birthday) 84 YRS.					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Md					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH AAA CO					Md.									
10. CITY OR TOWN OF DEATH Pasadena					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 16 Granada Rd					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife					12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md					13b. COUNTY AA Co					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER 16 Granada Rd									
14. FATHER'S NAME First Robert Middle Shipley Last					15. MOTHER'S MAIDEN NAME First Mary Ellen Middle Ford Last																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT Edward Webster					Address Same														
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CVA with left hemiplegia DUE TO, OR AS A CONSEQUENCE OF (c) essential hypertension															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years 8 years 10 years														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) none																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from July 10, 1952 to Feb. 6, 1969 , that (I) (we) last saw the deceased alive on Feb. 3, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE R.M. McLaughlin															DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 2/6/69									
22d. PHYSICIAN'S NAME (Type) R.M. McLaughlin															22e. ADDRESS 3708 Mountain Road, Pasadena, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 2/8/69					23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem					23d. LOCATION (City or Town) (County) (State) Balto, Md														
24. FUNERAL DIRECTOR Me. Cully F.H. 737 Satapasco ave.															ADDRESS					25a. REC'D BY REGISTRAR DATE FEB 13 1969					25b. REGISTRAR'S SIGNATURE Charles Judge				

01883

UNITED STATES OF AMERICA

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

01934

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01928

1. DECEASED NAME (Type or print)		First Middle Last		2o. DATE OF DEATH		Month Day Year		2b. HOUR AM PM	
Charles W.		Whayland		February		24 1969		11:15	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Male		White		9-30-03		65 YRS.			
7o. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Delaware		United States				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie		North Arundel Hospital		Principal		Education			
13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Anne Arundel		Annapolis		YES		15 Murray Avenue	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last							
Wahter		WHAYLAND		uyk.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
NO				ELIZABETH A. WHAYLAND #13					
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19o. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20o. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21o. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Port 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 2-12-69, to 2-24-69, that (I) (we) last saw the deceased alive on 2-24-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Hilary T. O'Herlihy								2-24-69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Hilary T. O'Herlihy		325 Hospital Drive Glen Burnie, Maryland							
23o. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		2-27-69		CEDAR BLUFF		ANNE ARUNDEL CO. MD.			
24. FUNERAL DIRECTOR		ADDRESS		25o. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John M. Foxworth Annapolis, Md.				FEB 27 1969		Charles J. ...			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First BYRON			Middle C			Last WHITEN			2a. DATE OF DEATH 2- Month Day 10 Year 69			2b. HOUR 9:00 P M		
3. SEX Male			4. RACE Negro			5. DATE OF BIRTH 1-18-69			6. AGE (In years last birthday) 21 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Holt, Md			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH A.A. Md.								
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b. COUNTY A.A.			13c. CITY OR TOWN Glen Burnie			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 301 Cherry Lane					
14. FATHER'S NAME Harry			First Harry			Middle Whiten			15. MOTHER'S MAIDEN NAME Patience Whiten			First Patience			Middle Whiten		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. N			17. INFORMANT Chart			Address North Arundel								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>2/10</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Alvin M. Hecker MD</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) Dr. Alvin Hecker												22e. ADDRESS 310 Crain Highway, S.W., Glen Burnie, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 1-13-69			23c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem			23d. LOCATION (City or town) (County) (State) Baltimore Md								
24. FUNERAL DIRECTOR <u>Elroy W. Loefer 1000 B remington</u> ADDRESS						25a. REC'D BY REGISTRAR DATE FEB 14 1969			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

01936										01930														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print) Chester Alden WICKSTROM					2a. DATE OF DEATH Month February Day 27 Year 1969					2b. HOUR A. 10:38														
3. SEX Male			4. RACE White			5. DATE OF BIRTH Sept. 28, 1907			6. AGE (In years last birthday) 61 YRS.			IF UNDER 1 YEAR MONTHS DAYS 			IF UNDER 24 HRS. HOURS MIN 									
7a. BIRTHPLACE (State or foreign country) New York			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.															
10. CITY OR TOWN OF DEATH Annapolis					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Insurance Agent					12b. KIND OF BUSINESS OR INDUSTRY Insurance									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland					13b. COUNTY Anne Arundel					13c. CITY OR TOWN Riva					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER				
14. FATHER'S NAME First Charles Middle Wickstrom Last 					15. MOTHER'S MAIDEN NAME First Augusta Middle LARSON Last 																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes: give war or dates of service) -					16b. SOCIAL SECURITY NO. 090-096050					17. INFORMANT Evelyn H. Wickstrom					Address #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Hours														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) PREVIOUS CORONARY THROMBOSIS																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from 5-6 , 19 65 , to 2-27 , 19 69 , that (I) (we) last saw the deceased alive on 2-27 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.										22b. SIGNATURE Edward S. Beck DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.					22e. ADDRESS 73 Franklin St., Annapolis, Md.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE 3-2-69					23c. NAME OF CEMETERY OR CREMATORY HIGHCREST					23d. LOCATION (City or Town) (County) (State) Annapolis A.H. Md.									
24. FUNERAL DIRECTOR John M. Lytle & Sons					ADDRESS Annapolis, Md.					25a. REC'D BY REGISTRAR MAR 3 1969					25b. REGISTRAR'S SIGNATURE John M. Lytle									

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print) <i>Sandra Renee Williams</i>					2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month <i>2</i> Day <i>15</i> Year <i>1969</i>		2b. HOUR <i>A</i> M		
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>8/29/68</i>	6. AGE (In years last birthday) <i>5</i> YRS. <i>17</i>	IF UNDER 1 YEAR MONTHS <i>5</i> DAYS <i>17</i>	IF UNDER 24 HRS. HOURS <i>17</i> MIN.	2c. DATE PRONOUNCED DEAD Month <i>✓</i> Day <i>15</i> Year <i>1969</i>		2d. HOUR <i>A</i> M	
7a. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel Co.</i> Md.			
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>5011 NORTH ARUNDEL</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i> COUNTY <i>AA</i>			13b. CITY OR TOWN <i>Glen Burnie</i>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>59 Chester Circle</i>		
14. FATHER'S NAME First <i>James</i> Middle <i>P.</i> Last <i>Jr.</i>			15. MOTHER'S MAIDEN NAME First <i>Marietta</i> Middle <i>Gramley</i> Last <i>Gramley</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <i>---</i>			17. INFORMANT ADDRESS <i>James P. Williams, Jr., Same as 13</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>795X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>SO II</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Shaken</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>E. Linhardt</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>2/15/69</i>			
EXAMINER'S NAME (Type) <i>E. Linhardt</i>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county) <i>A.A. Co.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>17 Feb. 69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Memorial</i>		23d. LOCATION (City or Town) <i>Glen Burnie, AA, Md.</i>		23e. (County) (State)	
24. FUNERAL DIRECTOR ADDRESS <i>Kirkley Funeral Home, Glen Burnie, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>FEB 17 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judson</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		20. DATE OF DEATH			2b. HOUR
MARY IRENE WINDSOR								FEB Month 25 Day 1969 Year			10 ⁰⁰ P.M.
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
FEMALE		CAUCASIAN		JUNE 24, 1883			85 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
WASHINGTON, DC.		U. S.				ANNE ARUNDEL Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
MILLERSVILLE			KNOLLWOOD MANOR NURSING HOME								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND			ANNE ARUNDEL		HARWOOD				Box 168A CUMBERSTONE RD.		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
John F. Hutcherson									Margaret Manion		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
no			579-20-8025		Walter H. Windsor, Son			Box 168A Cumberstone Rd., Harwood, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5909</u> <u>INANITION, PROGRESSIVE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>KIDNEY INFECTION, CHRONIC</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u> <u>MANY YEARS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>SENILITY, ARTERIOSCLEROSIS, MULTIPLE DECUBITUS ULCERS.</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1 OCT</u> , 19 <u>68</u> , to <u>25 FEB</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>20 FEB</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS.		22c. DATE SIGNED	
<u>Charles W. Kinzer</u>				<input checked="" type="checkbox"/>						FEBRUARY 25, 1969	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
CHARLES W. KINZER, M.D.		16 MURRAY AVE., ANNAPOLIS, MARYLAND.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		2/28/69		Arlington National		Arlington, Virginia					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Robert E. Wilhelm Funeral Home		4308 Suitland Road, S. E., Wash., D. C., 20023		DATE MAR 4 1969		<u>Charles Judge</u>					

01989

11502

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1801.

2. The second part is a letter from the President to the Congress, dated January 1, 1801.

3. The third part is a letter from the President to the Congress, dated January 1, 1801.

4. The fourth part is a letter from the President to the Congress, dated January 1, 1801.

5. The fifth part is a letter from the President to the Congress, dated January 1, 1801.

6. The sixth part is a letter from the President to the Congress, dated January 1, 1801.

7. The seventh part is a letter from the President to the Congress, dated January 1, 1801.

8. The eighth part is a letter from the President to the Congress, dated January 1, 1801.

9. The ninth part is a letter from the President to the Congress, dated January 1, 1801.

10. The tenth part is a letter from the President to the Congress, dated January 1, 1801.

11. The eleventh part is a letter from the President to the Congress, dated January 1, 1801.

12. The twelfth part is a letter from the President to the Congress, dated January 1, 1801.

13. The thirteenth part is a letter from the President to the Congress, dated January 1, 1801.

14. The fourteenth part is a letter from the President to the Congress, dated January 1, 1801.

15. The fifteenth part is a letter from the President to the Congress, dated January 1, 1801.

16. The sixteenth part is a letter from the President to the Congress, dated January 1, 1801.

17. The seventeenth part is a letter from the President to the Congress, dated January 1, 1801.

18. The eighteenth part is a letter from the President to the Congress, dated January 1, 1801.

19. The nineteenth part is a letter from the President to the Congress, dated January 1, 1801.

20. The twentieth part is a letter from the President to the Congress, dated January 1, 1801.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
30M REV. 1/69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
01939						CERTIFICATE OF DEATH			01933		
1. DECEASED-NAME (Type or print) First Middle Last Ruth Kathleen Woelfel						2a. DATE OF DEATH Feb Month 3 Day 1969 Year			2b. HOUR 8:15 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 23, 1900		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Winch, Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Annapolis Convalescent			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY A.A. Co		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Severn Grove Road		
14. FATHER'S NAME First Middle Last ? Gibbons				15. MOTHER'S MAIDEN NAME First Middle Last ? Eagle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 215-48-2010		17. INFORMANT George B. Woelfel Jr.			Address Annapolis, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 340 X IMMEDIATE CAUSE (a) MULTIPLE SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 YEARS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (1) (this hospital) attended the deceased from July, 1953, to Feb, 1969, that (1) (we) lost saw the deceased alive on Feb 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edward S. Beck MD						DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3 Feb 69	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Feb 3, 1969		23c. NAME OF CEMETERY OR CREMATORY St Annes Cemetery		23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Co					
24. FUNERAL DIRECTOR Abrahamson				ADDRESS Annapolis, Md		25a. REC'D BY REGISTRAR DATE FEB 10 1969		25b. REGISTRAR'S SIGNATURE			

1933

UNITED STATES OF AMERICA

1933

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 01940 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01934 </div>												
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR			
<div style="display: flex; justify-content: space-between;"> First Middle Last </div> Wilhemia Wolf						Month 2 Day 24 Year 69			4:40pm			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		1887			81 YRS.		MONTHS	DAYS	HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Germany			USA						Anne Arundel Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Crownsville			Crownsville State Hospital									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Maryland				Balto		Baltimore		3617 E. Lombard Street				
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME								
<div style="display: flex; justify-content: space-between;"> First Middle Last </div> Simon Wolf				<div style="display: flex; justify-content: space-between;"> First Middle Last </div> Pauline Bubeck								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, ar unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
no				unknown		Hospital Records, Crownsville State Hospital						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac failure 011.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic pulmonary fibrosis DUE TO, OR AS A CONSEQUENCE OF (c) pulmonary tuberculosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs -		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) H.S. V.D. - malnutrition												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street ar R.F.D. No.		City ar Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from 2/6 , 19 69 , to 2/24 , 19 69 , that (I) (we) last saw the deceased alive on 2/24 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Alberto Gonzalez DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED 2/24/69				
22d. PHYSICIAN'S NAME (Type) Alberto Gonzalez, M.D.								22e. ADDRESS Crownsville State Hospital, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)				
BURIAL		3/7/69		OAK LAWN				BALTO. MD.				
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
J.G. CONNELLY SONS 300 MACE						MAR 6 1969		Charles Jones				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01941

01935

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>				c. LENGTH OF STAY IN 1b <u>45 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>Box 435 Route 2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Albert</u> First <u>Zalud</u> Middle <u>Zalud</u> Last			4. DATE OF DEATH <u>Feb</u> Month <u>8</u> Day <u>19</u> Year <u>69</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18 1887</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Correction Officer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of Correction</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chicago, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Albert Zalud</u>			14. MOTHER'S MAIDEN NAME <u>Rosemary Castle</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>218 28 9421 A</u>		17. INFORMANT <u>Emma Zalud</u> Address <u>Jessup, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4124 DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> (c) <u>Diabetes Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , 19 <u>58</u> , to <u>2-8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-8</u> 19 <u>69</u> , and that death occurred at <u>9:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Jose M. Yosuvico</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>2-8-69</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSE M. YOSUVICO</u>			22d. ADDRESS <u>704 GORMAN AVE, LAUREL MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Feb. 11 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Madewood Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Berwyn Howard Co. Md</u>	
24. FUNERAL DIRECTOR <u>Donaldson Funeral Home</u>			ADDRESS <u>Laurel Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 13 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

41232

UNITED STATES DEPARTMENT OF AGRICULTURE

01001

FEB 13 1988

CERTIFICATE OF DEATH

01936

Reg. Dist. No.

01942

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A. D.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARVEL BEACH</u>				c. LENGTH OF STAY IN 1b <u>10 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>440 CARVEL BEACH ROAD</u>				d. STREET ADDRESS <u>440 CARVEL BEACH RD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM FRANKLIN ZIMMERMAN</u>				4. DATE OF DEATH Month Day Year <u>FEB. 2 1969</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 9, 1986</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PLUMBING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES FRANKLIN ZIMMERMAN</u>				14. MOTHER'S MAIDEN NAME <u>EMMA E. WECKESSER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-48-1807</u>		17. INFORMANT <u>GRACE E. ANDERSON - SAME</u>			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> <u>4124</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV. 1968</u> to <u>FEB 2, 1969</u> , that I last saw the deceased alive on <u>1/31</u> , 19 <u>69</u> , and that death occurred at <u>8:55 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Brady Smith</u>				ADDRESS (Street, city or town, state) <u>9471 F. SMALLWOOD ROAD</u>		DATE SIGNED <u>2/1/69</u>	
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>				PASADENA, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/5/1969</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond C. Fink</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 4 1969</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

